

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/02/2024
NAME OF PROVIDER OR SUPPLIER  Silver Creek Rehab & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7 Creek Lane Bristol, RI 02809	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>43987</p> <p>Based on record review and staff interview it has been determined that the facility failed to keep a resident free from physical abuse for 1 of 4 residents reviewed, Resident ID #4.</p> <p>Findings are as follows:</p> <p>Review of the facility policy titled Abuse prohibition states in part, .It is the policy of this facility to ensure that all residents are treated with respect and dignity and that all residents are free from abuse .Definitions: Abuse: Willful infliction of injury .and includes physical, verbal, sexual, and mental abuse. Examples of abuse include but are not limited to the following .Physical-Hitting, punching, pinching, kicking .</p> <p>Record review of a facility incident report submitted to the Rhode Island Department of Health on 6/24/2024, indicates that Resident ID #s 4 and 5 were participating in a coloring activity in a common area and had a disagreement. The perpetrator, Resident ID #5 grabbed a pen and made contact with the victim, Resident ID #4's, hand causing a skin tear that required medical treatment.</p> <p>Record review revealed that Resident ID #4 was admitted to the facility in January of 2021 with diagnoses including, but not limited to, dementia without behavioral disturbances and anxiety.</p> <p>Review of the Minimum Data Set (MDS) Assessment for Resident ID #4 dated 7/3/2024, revealed a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating that the resident's cognition was moderately impaired.</p> <p>Record review of Resident ID #4 progress notes revealed the following:</p> <p>-4/22/2024 a nursing note that revealed that Resident ID #4 was participating in a group coloring activity when Resident ID #5 got upset and aggressive towards him/her for throwing pencils on the ground. Resident ID #5 had pencils in his/her hand and injured Resident ID #4's left hand resulting in a skin tear requiring treatment. Resident ID #5 was also observed by staff to be kicking Resident ID #4 in the legs.</p> <p>-4/23/2024, revealed a social service note authored by Social Worker, Staff I, that indicates she met with Resident ID #4 after the incident with Resident ID #5 and that Resident ID #4 expressed feeling pain in his/her left hand.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a skin observation tool dated 4/22/2024 revealed that Resident ID #4 had a skin tear to the back of his/her left hand measuring 2.5 centimeters (cm) in length by 2.0 cm in width by 0.1 cm in depth.</p> <p>Review of the physician's orders revealed an order dated 4/24/2024 for a skin tear on the left hand to wash with normal saline followed by Medi honey (gel/ointment use to treat wounds) and a dry sterile dressing to be applied in the evening and to discontinue once resolved. The order had a start date of 4/25/2024 and was discontinued on 5/11/2024.</p> <p>Record review revealed that Resident ID #5, was admitted to the facility in July of 2023 with diagnoses including, but not limited to, dementia and depression.</p> <p>Review of a Quarterly MDS Assessment for Resident ID #5 dated 3/22/2024, revealed a BIMS score of 6 out of 15, indicating severe cognitive impairment.</p> <p>Review of Resident ID #5's care plan dated 4/26/2024 failed to reveal evidence that interventions were put into place relative to the incident of physical aggression towards Resident ID #4 on 4/22/2024.</p> <p>Record review of a progress note dated 4/22/2024 for Resident ID #5, revealed that s/he was observed by staff becoming agitated and aggressive with Resident ID #4. Additionally, the progress note revealed that Resident ID #5 grabbed the pencils and caused a skin tear to Resident ID #4's left hand. It further revealed that Resident ID #5 was observed kicking Resident ID #4.</p> <p>During a surveyor interview on 7/30/2024 at 3:34 PM with the Director of Nursing Services, he acknowledged that Resident ID #4 sustained a skin tear caused by Resident ID #5 and that it is considered physical abuse as described in the facility policy. Additionally, he was unable to provide evidence that the facility kept Resident ID #4 free from physical abuse.</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43987</p> <p>Based on record review and staff interview it has been determined that the facility failed to ensure that residents who require supervision with meals, received supervision when eating, for 1 of 4 residents reviewed, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Review of a facility reported incident received by the Rhode Island Department of Health on [DATE] revealed that Resident ID #1 experienced a choking incident at 4:17 PM, the Heimlich maneuver (first aid method used when a person is choking) was initiated followed by Cardiopulmonary Resuscitation (CPR). The facility contacted Emergency Medical Services (EMS) and the resident was transported to the Hospital at 5:00 PM where s/he expired.</p> <p>Record review of the EMS report revealed that they were dispatched to the facility for a resident with airway obstruction, who was unconscious and not breathing. The facility communicated with EMS that the resident was eating pizza for dinner in his/her room when s/he choked causing complete airway obstruction and s/he started turning blue. The resident's roommate called for help and the facility staff found the resident actively choking. The facility staff attempted to perform the Heimlich maneuver without success. At this time the resident became unconscious, and the facility staff assisted Resident ID #1 to the floor and chest compressions were started. Per the EMS report the facility staff attempted to manually remove the foreign body via suctioning without success and then proceeded to call 911. When EMS arrived the resident's airway was completely compromised. High quality CPR was being performed by the facility staff and the automated external defibrillator (a device that can help restart a person's heart during cardiac arrest) was attached to the resident and s/he was being passively ventilated. The suction canister next to the resident had blood and secretions in the tubing after the facility staff attempted removal of the foreign body. EMS took over resuscitation efforts and initiated continuous compressions. EMS removed chunks of melted cheese and bread from his/her airway, and they continued to suction copious (large in quantity) amounts of blood and secretions until the airway was patent (open). The procedure took approximately 10 minutes until the airway was completely clear of the obstruction. EMS was unable to intubate due to the copious amount of blood and secretions. Nine rounds of epinephrine (a medication that is used in an emergency to increase blood circulation and breathing) were administered to the resident with no improvement. Resuscitation continued for 30 minutes at the facility and then the resident was transported to the hospital where s/he was pronounced deceased .</p> <p>Record review revealed that Resident ID #1 was readmitted to the facility in October of 2020 with diagnoses including, but not limited to, Barrett's esophagus (a change in the cellular structure of the esophagus lining in which a patient can develop difficulty swallowing), hemiplegia (paralysis in one side of the body), and hemiparesis (muscle weakness on one side of the body) following a stroke, and dementia.</p> <p>Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating the resident is cognitively intact. Additionally, the assessment revealed that the resident required supervision of one staff member when eating.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of a comprehensive care plan revealed the following:</p> <p>-[DATE] a focus area indicating that the resident receives a therapeutic mechanically altered diet related in part to dysphagia (difficulty swallowing). Interventions include monitoring, reporting signs and symptoms of dysphagia, and documenting; pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat and/or appearing concerned during meals.</p> <p>-[DATE] a focus area for dental care related to the resident being edentulous (having no teeth). Interventions are to monitor for discomfort or difficulty chewing.</p> <p>Review of a physician's order dated [DATE] revealed a consistent carbohydrate diet (CCD), minced and moist in texture. In addition, it includes directions for low lactose, small portions, built up utensils, a plate guard with meals and no carrots.</p> <p>Review of the Speech Therapy Discharge Summary dated [DATE] authored by Speech Language Pathologist (SLP), Staff A, revealed that the resident had a skilled intervention to follow safe swallowing strategies. Additionally, the summary indicates recommendations for a minced and moist textured diet to safely swallow solid foods.</p> <p>Record review of a nursing assistant task document titled ADL [Activities of Daily Living]-Eating, Question 2 describes the following, EATING: SELF PERFORMANCE-How resident eats and drinks, regardless of skill . revealed the following:</p> <p>From [DATE] through [DATE]</p> <p>-For 9 out of 62 opportunities the resident was documented total dependence, full staff performance for eating.</p> <p>-For 30 out of 62 opportunities the resident was documented as needing supervision, oversight, encouragement or cueing for eating.</p> <p>Record review of the progress notes revealed the following:</p> <p>-[DATE], a nutritional/dietary note that revealed a quarterly nutritional assessment indicating the resident requires varying levels of assistance from set up to hands on assistance from staff for meals.</p> <p>-[DATE], a nursing note authored by Licensed Practical Nurse, Staff G, states in part, At approximately 1617 [4:17 PM] hours, while passing medications, this writer responded to [Resident ID #1] who called out for water. Upon entering the room, the resident was unable to speak and appeared to be choking. I called for help and immediately initiated the Heimlich maneuver. A code blue was initiated, EMS was called. Nurses throughout the building participated in CPR. EMS arrived at 1627 [4:27 PM] hours and took over resuscitation procedures .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview on [DATE] at 1:20 PM with SLP, Staff A, she revealed that the resident was last seen by speech in June of 2024. She indicated that the resident has no teeth, is impulsive, forgetful, and needed reminders to pace him/herself because s/he tends to eat at a fast rate. Additionally, Staff A revealed that whole pizza slices were not a part of the resident's prescribed diet. She further revealed that the resident required assistance and supervision from staff to remind him/her to swallow their food.</p> <p>During a surveyor interview on [DATE] at 2:40 PM with Nursing Assistant, Staff B, she revealed that the resident required supervision for all meals because s/he has a moist and minced modified diet. In addition, she revealed that when the resident desired to have food that was not minced and moist the resident could be easily redirected to get another snack or meal that was appropriate for his/her prescribed diet.</p> <p>During a surveyor interview on [DATE] at 1:13 PM with the resident's child, s/he revealed that s/he could not understand how another resident was allowed to give his/her parent [Resident ID #1] whole slices of pizza without the staff's knowledge, or why they were not monitoring him/her when s/he was eating the pizza, if they were aware s/he had whole slices of pizza. S/he further indicated that his/her stepchild, who works at a pizzeria, brought in a special made pizza for the resident's birthday approximately a week prior. The pizza was prepared moist and minced, as the family was aware of the resident's modified diet. Furthermore, when the pizza was brought into the facility for the resident on his/her birthday, a nurse approved the pizza prior to the resident's consumption, and the family supervised the resident while s/he ate it in its entirety.</p> <p>During a surveyor interview on [DATE] at 3:04 PM, with Registered Nurse (RN), Staff C, she indicated that on [DATE], while she was receiving a nurse to nurse report and preparing to count medications, she saw a pizza delivery person heading towards Resident ID #2's room. Staff C completed the medication count and proceeded to Resident ID #2's room. She discovered that Resident ID #2 had given 2 slices of whole pizza to Resident ID #1. Staff C found Resident ID #1 in his/her room, with 2 whole pizza slices on a plate. Staff C tried to educate the resident about the potential choking hazards of eating pizza, but the resident reacted defensively. She then left the resident unsupervised and went upstairs to inform RN's, Staff D, and E about the situation. After discussing with them, she went back downstairs and discussed the situation with RN, Staff F. At that time someone suggested getting the speech pathologist. Staff C made her way to the speech pathologist's office, but she was not there.</p> <p>Further interview with RN, Staff C revealed that she then returned to Resident ID #1's room and noticed that the resident had almost finished the pizza, as only the crust remained on the plate. She tried to educate the resident but the resident, stated she had pizza for his/her birthday. Staff C stated that she left the resident with the pizza crust on the plate. Later, while preparing to administer pain medication to another resident, she heard another staff member screaming for help and found 3 other nurses in the resident's room where she observed the resident trying to speak but the words were not clear. The Heimlich maneuver was initiated but was unsuccessful and CPR was started. EMS arrived on site, took over CPR and attempted to intubated and suction the resident. EMS finally transported the resident to the hospital after approximately 43 minutes of resuscitation. Additionally, Staff C acknowledged that she left the resident without supervision in his/her room on [DATE] on two occasions, and that she was aware that the pizza was not approved for his/her modified diet of a minced and moist texture.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review revealed that Resident ID #2 was readmitted to the facility in May of 2024 with diagnoses including, but not limited to, Chronic Obstructive Pulmonary Disease and generalized muscle weakness.</p> <p>Review of an MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, indicating the resident is cognitively intact.</p> <p>During a surveyor interview on [DATE] at 1:40 PM with Resident ID #2, s/he revealed that on [DATE] s/he ordered a pizza. S/he indicated that the delivery person was assisting him/her with the food. Resident ID #1 approached the door and asked for some pizza. Resident ID #2 instructed the delivery person to give 2 slices of pizza to Resident ID #1. Resident ID #1 then took the pizza and returned to his/her room. Resident ID #2 further revealed that s/he informed RN, Staff C, that s/he gave 2 slices of whole pizza to Resident ID #1. Furthermore s/he stated that Staff C told him/her that s/he should not have given the pizza to Resident ID #1.</p> <p>During a surveyor interview on [DATE] at 11:34 AM with the Director of Nursing Services, he acknowledged that the resident expired from choking on slices of whole pizza that the resident consumed.</p> <p>The facility failed to provide Resident ID #1 with adequate supervision while s/he was eating whole pizza slices which is not the resident's ordered diet texture. Staff C was aware that the resident was given whole pizza slices by another resident, and she left the resident unsupervised on two occasions to eat the pizza independently. This failure resulted in Resident ID #1 choking on whole pizza slices, received the Heimlich maneuver and CPR, being suctioned, received 9 rounds of epinephrine and later expired at the hospital.</p>		

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<p>F 0805</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43987</p> <p>Based on record review, and staff interview, it has been determined that the facility failed to ensure that residents receive and consume food in the appropriate form for 1 of 4 residents reviewed for a modified diet of the minced and moist texture, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Review of a facility reported incident received by the Rhode Island Department of Health on [DATE] revealed that Resident ID #1 experienced a choking incident at 4:17 PM, the Heimlich maneuver (first aid method use when a person is choking) was initiated followed by Cardiopulmonary Resuscitation (CPR). The facility contacted Emergency Medical Services (EMS) and the resident was transported to the Hospital at 5:00 PM where s/he expired.</p> <p>Record review of the EMS report revealed that they were dispatched to the facility for a resident with airway obstruction, was unconscious and was not breathing. The facility communicated with EMS that the resident was eating pizza for dinner in his/her room when s/he choked causing complete airway obstruction and s/he started turning blue. The resident's roommate called for help and the facility staff found the resident actively choking. The facility staff attempted to perform the Heimlich maneuver without success. At this time the resident became unconscious, and the facility staff assisted Resident ID #1 to the floor and chest compressions were started. Per the EMS report the facility staff attempted to manually remove the foreign body via suctioning without success and then proceeded to call 911. When EMS arrived the resident's airway was completely compromised. High quality CPR was being performed by the facility staff and the automated external defibrillator (a device that can help restart a person's heart during cardiac arrest) was attached to the resident and s/he was being passively ventilated. The suction canister next to the resident had blood and secretions in the tubing after the facility staff attempted removal of the foreign body. EMS took over resuscitation efforts and initiated continuous compressions. EMS removed chunks of melted cheese and bread from his/her airway, and they continued to suction copious (large in quantity) amounts of blood and secretions until the airway was patent. The procedure took approximately 10 minutes until the airway was completely clear of the obstruction. EMS unable to intubate due to the copious amount of blood and secretions. Nine rounds of epinephrine (a medication that is used in an emergency to increase blood circulation and breathing) were administered to the resident with no improvement. Resuscitation continued for 30 minutes at the facility and then the resident was transported to the hospital where s/he was pronounced deceased .</p> <p>Record review revealed that Resident ID #1 was readmitted to the facility in October of 2020 with diagnoses including, but not limited to, Barrett's esophagus (a change in the cellular structure of the esophagus lining in which a patient can develop difficulty swallowing), hemiplegia (paralysis in one side of the body), and hemiparesis (muscle weakness on one side of the body) following a stroke, and dementia.</p> <p>Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating the resident is cognitively intact. Additionally, the assessment revealed that the resident required supervision of one staff member when eating.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Further interview with RN, Staff C revealed that she then returned to Resident ID #1's room and noticed that the resident had almost finished the pizza, as only the crust remained on the plate. She tried to educate the resident, but the resident stated she had pizza for his/her birthday. Staff C stated that she left the resident with the pizza crust on the plate. Later, while preparing to administer pain medication to another resident, she heard another staff member screaming for help and found 3 other nurses in the resident's room where she observed the resident trying to speak but the words were not clear. The Heimlich maneuver was initiated but was unsuccessful and CPR was started. EMS arrived on site, and they took over CPR, attempted to intubate and suction the resident, finally they transported him/her to the hospital. Additionally, Staff C acknowledged the whole pizza slices were not approved for his/her modified diet of minced and moist texture.</p> <p>Record review revealed that Resident ID #2 was readmitted to the facility in May of 2024. Review of an MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, indicating the resident is cognitively intact.</p> <p>During a surveyor interview on [DATE] at 1:40 PM with Resident ID #2, s/he revealed that on [DATE] s/he ordered pizza. S/he indicated that the delivery person was assisting him/her with the food. Resident ID #1 approached the door and asked for some pizza. Resident ID #2 instructed the delivery person to give 2 slices of pizza to Resident ID #1. Resident ID #1 then took the pizza and returned to his/her room. Resident ID #2 further revealed that s/he informed RN, Staff C, that s/he gave 2 slices of whole pizza to Resident ID #1. Furthermore s/he stated that Staff C told him/her that s/he should not have given the pizza to Resident ID #1.</p> <p>During a surveyor interview on [DATE] at 11:34 AM with the DNS, he revealed that he would have expected someone to have been with the resident while s/he was eating the pizza. He acknowledged that the resident expired from choking on slices of whole pizza that the resident consumed.</p> <p>During a surveyor interview on [DATE] at 1:13 PM with the resident's child, s/he revealed that s/he could not understand how another resident was allowed to give his/her parent [Resident ID #1] whole slices of pizza without the staff's knowledge, or why they were not monitoring him/her when s/he was eating the pizza, if they were aware s/he had whole slices of pizza. S/he further indicated that his/her stepchild, who works at a pizzeria, brought in a special made pizza for the resident's birthday approximately a week prior. The pizza was prepared moist and minced, as the family was aware of the resident's modified diet. Furthermore, when the pizza was brought into the facility for the resident on his/her birthday, a nurse approved the pizza prior to the resident's consumption, and the family supervised the resident while s/he ate it in its entirety.</p> <p>The facility failed to ensure that Resident ID #1 received food in the appropriate form as s/he was observed by Staff C eating whole pizza slices which is not the resident's ordered diet texture. Staff C was aware that the resident was given whole pizza slices by another resident, and she left the resident unsupervised on two occasions to eat the pizza independently. This failure resulted in Resident ID #1 choking on whole pizza slices, received the Heimlich maneuver and CPR, being suctioned, received 9 rounds of epinephrine and later expired at the hospital.</p>		