STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415035	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincolnwood Rehabilitation and Healthcare Center	610 Smithfield Road North Providence, RI 02904

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50004 Based on record review and staff interview, it has been determined that the facility failed to provide written notice of the bed-hold policy to the resident or resident representative, prior to the transfer of the resident to the hospital, for 1 of 3 residents reviewed, Resident ID #1. Findings are as follows: Record review of a community reported complaint submitted to the Rhode Island Department of Health on 8/23/2024 alleges that, Resident ID #1 was discharged from the facility to the hospital on 8/8/2024. On 8/16/2024, the hospital case manager was informed by the facility that the resident was a short-term resident (the resident had been residing in the facility for 2 years), and the facility no longer had any available beds. Record review revealed that Resident ID #1 was admitted to the facility in August of 2022 with a diagnosis including, but not limited to, Alzheimer's disease. Review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 00 out of 15, indicating severe cognitive impairment. Record review of a progress note dated 8/8/2024, revealed that the resident woke up at 4:00 AM and was wandering and became aggressive with staff, hitting a nursing assistant on the back of his head as he was walking away. The physician was notified and gave an order to send the resident to the hospital related to aggressive behaviors. Record review of a progress note dated 8/22/2024 authored by the Administrator revealed that she spoke with the resident's daughter after receiving her letter. The Administrator informed the daughter that the resident's room had been packed up and stored because there was no bed hold in place. During a surveyor interview on 8/26/2024 at approximately 4:00 PM with the resident's daughter, she revealed that she was not contacted by the facility or offered a bed hold verbally or in writing during the resident's hospitalization . (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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's hospital record revealed Case Management notes dated 8/16/2024, indicating that the facility was contacted to coordinate the discharge of the resident back to the facility that s/he had been living in for 2 years. The facility did not respond to the online care management system relative to accepting the resident's return. Additionally, the Case Manager called the facility and left a message for the Director of Nursing Services (DNS) and a response was not received. The case manager also reached out to the Long-Term Care Ombudsman office for assistance. The notes further revealed that the resident's daughter was upset that the facility would not allow her parent to return to their home and could not understand why. During a surveyor interview on 8/28/2024 at approximately 12:20 PM, with the DNS, she revealed that she spoke with the resident's daughter the day after the resident was sent to the hospital let the daughter know that someone from Admissions or Social Services would contact her to discuss the bed hold policy. She further acknowledged that she did not discuss the bed hold policy with the resident's daughter because she does not know the actual cost of a bed hold. During a surveyor interview on 8/28/2024 at approximately 1:00 PM with the Admissions Director, she acknowledged that she did not provide Resident ID #1 with a bed hold policy in writing with the required information prior to the resident being transferred to the hospital on 8/8/2024. Additionally, she was unaware if anyone from the facility contacted the resident's daughter to discuss the bed hold after s/he was sent to the hospital. During a surveyor interview with the Administrator on 8/28/2024 at approximately 1:20 PM, she was unable to provide evidence that a written notice of the facility's bed hold policy was given to the resident when s/he was transferred to the hospital on 8/8/2024 and was unaware if anyone from the facility contacted the resident's daughter. She further revealed that the facility did not have any beds available for this resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50004 Based on 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 following physician orders for obtaining appointments with specialists for 1 of 3 residents reviewed, Resident ID #2. Findings are as follows: Record review of a community reported complaint submitted to the Rhode Island Department of Health on 8/19/2024 alleges that Resident ID #2 was admitted to the facility in July of 2024 with several follow-up appointments scheduled for August 2024, including a cardiology follow-up appointment. Additionally, the complaint alleges that the facility was aware of these appointments and failed to obtain transportation for the resident to get to his/her appointments. Record review revealed that Resident #2 was admitted to the facility in July of 2024 with diagnoses including, but not limited to, heart failure, end stage renal disease and diabetes. Review of a hospital discharge summary dated 7/25/2024 states in part, .You were seen at [hospital name] for worsening heart failure .and newly diagnosed heart arrhythmia [a heartbeat that can be too fast, too slow, or irregular] . Additionally, the report revealed a follow-up appointment with a cardiologist was scheduled for 8/20/2024 at 2:00 PM. Record review of a laboratory document dated 8/12/2024 revealed bloodwork titled, B-type Natriuretic Peptide (BNP, a test that measures the levels of a hormone in your blood. Higher levels can be a sign of heart failure or other serious heart problems.) BNP result of greater than 70,000.00 PG/ML (picograms per milliliter; the normal reference range is 0 - 300.00 PG/ML). Record review of a progress note dated 8/13/2024 authored by the Nurse Practitioner (NP), Staff A, following her review of the resident's critical BNP level, revealed she wrote new orders for the resident to have follow-up appointments with cardiology and hematology, and to obtain a Gastroenterologist (GI) consult. Further record review failed to reveal evidence that an appointment for hematology or a GI consult were scheduled. During a surveyor interview on 8/28/2024 at approximately 9:30 AM with the Patient Scheduler from the resident's cardiology office, he revealed that the resident had an appointment booked for 8/20/2024 and did not show up. He further revealed that the office has tried to contact the facility twice, because the cardiologist wants to see the patient as soon as possible, and left messages but no one has returned either call to schedule an appointment. During a surveyor interview on 8/28/2024 at 12:09 PM, with the Staff A, she acknowledged that she gave an order on 8/13/2024 for the resident to be seen by hematology, GI and cardiology and would have expected those appointments to have already been scheduled and for the resident to have attended the cardiologist appointment that s/he had on 8/20/2024 and stated, This appointment is critical. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 8/28/2024 at approximately 12:20 PM, with the Director of Nursing Services, she was unable to provide evidence that the above mentioned appointments were scheduled or attempted to be scheduled with hematology or GI per the physician's order on 8/13/2024. Additionally, she was unable to explain why the resident missed his/her cardiology appointment on 8/20/2024.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 50004 Based on record review and staff interview it has been determined that the facility failed to ensure that all residents are free from significant medication errors relative to the administration of medications to the incorrect resident, for 1 of 1 resident reviewed, Resident ID #5. Findings are as follows: Review of a community reported complaint received by the Rhode Island Department of Health on 8/21/2024 alleged that Resident ID #5 received another resident's medications on 8/13/2024. Record review revealed that the resident was admitted to the facility in August of 2024 with diagnoses including, but not limited to, pneumonia and abnormal weight loss. Review of a progress note dated 8/9/2024 revealed the resident received his/her roommates' medications and it was reported to the nurse practitioner with new orders to monitor the resident for low blood pressure. Review of a facility document titled Full QA Report dated 8/9/2024, states in part, .received roommates' medication today .nurse did not perform 5 checks .wrong resident . Additionally, the document revealed that the resident received hydralazine 50 milligrams (mg) and labetalol 200 mg (medications used to treat high blood pressure). Additionally, review of an addendum to the document above dated 8/28/2024 authored by the Director of Nursing Services, states in part, .resident became hypotensive [blood pressure was low] but was asymptomatic .new order obtained to give the resident IV [intravenous] fluids . During a surveyor interview on 8/28/2024 at approximately 2:50 PM with the Director of Nursing Services she acknowledged that the resident received his/her roommate's medications, which resulted in him/her experiencing low blood pressure and requiring IV fluids.