| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 415035 | A. Building<br>B. Wing | 09/18/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lincolnwood Rehabilitation and Healthcare Center | 610 Smithfield Road<br>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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>46338<br><br>Based on record review and staff interview, it has been determined that the facility failed to immediately inform the resident's representative relative to the decision to transfer a resident to an acute care hospital for one of one resident reviewed, Resident ID #3.<br><br>Findings are as follows:<br><br>Record review of a community reported complaint submitted to the Rhode Island Department of Health, dated 9/12/2024 alleges that the resident was transferred to an acute care hospital and his/her family was not notified.<br><br>Record review revealed the resident was readmitted to the facility in August of 2024 with diagnoses including, but not limited to, urinary tract infection, anemia, and Methicillin-Resistant Staphylococcus Aureus (MRSA).<br><br>Review of a nursing progress note authored by Licensed Practical Nurse, Staff A, revealed that on 8/23/2024 at 9:00 PM the resident was noted to not have any urinary output from his/her suprapubic catheter (a medical device that helps drain urine from your bladder). Additionally, the note indicated that the resident was complaining of abdominal pain so s/he was sent to the hospital per the provider's order. Further review of the note failed to reveal evidence that the family was made aware that the resident was sent to the hospital.<br><br>Review of a nursing progress note dated 8/24/2024 at 4:32 PM, the day after the resident was transferred to the hospital, authored by Registered Nurse, Staff B indicated that after receiving the resident's positive MRSA results from the laboratory, Staff B called Resident ID #3's daughter, Child #1, to notify her of the positive test results. Additionally, the note indicated that it was during this conversation that Child #1 learned that their parent, Resident ID #3 had been transferred and admitted to the hospital the day before and was not at the facility. Furthermore, the note revealed that Child #1 was upset because she was not made aware of the resident's transfer to the hospital ahead of time.<br><br>(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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a surveyor interview on 9/18/2024 at 9:58 AM with the Social Worker, Staff C, she revealed that she had placed a call to Resident ID #3's son, Child #2, on 8/28/2024, five days after the resident was transferred to the hospital, regarding holding the resident's bed while s/he was in the hospital. Child #2 indicated to Staff C that he had never been notified that the resident was transferred to the hospital and was no longer at the facility. Additionally, Staff C indicated that anytime there is a change of condition of a resident, or a resident is transferred to the hospital, nursing staff are supposed to inform the family.<br><br>A surveyor interview with Staff A was attempted on 9/18/2024 at approximately 11:00 AM, the nurse who obtained the order to transfer the resident to the hospital. Staff A was unable to be reached and the surveyor left a message, a return call was not received.<br><br>During a surveyor interview on 9/18/2024 at 3:10 PM with the Director of Nursing Services (DNS), the Administrator, and the Regional Nurse, the surveyor stated to them that she was unable to complete this investigation as Staff A was unable to be reached for an interview. At this time the DNS left the conference room and returned indicating that they had Staff A on the phone. During this interview with Staff A, he indicated that he called Resident ID #3's son, Child #2 on 8/23/2024 and informed him that the resident was being transferred to the hospital. At this time the surveyor indicated that Child #2 was not made aware that his parent was no longer at the facility and Staff A stated, then I must have spoken to the daughter. Staff A was informed that the daughter, Child #1 was not made aware that their parent was no longer at the facility either, and he stated, I don't remember who I spoke to. Furthermore, during this interview, The DNS, the Administrator, nor the Regional Nurse were able to provide evidence that the resident's children were notified of their parent's transfer to the hospital on 8/23/2024. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46338<br><br>Based on record review and staff interview, it has been determined that the facility failed to ensure that a resident receives treatment and care in accordance with professional standards of practice for 1 of 1 resident reviewed for a suprapubic catheter (a medical device that helps drain urine from your bladder into a collection bag outside of your body when you can't urinate on your own), Resident ID #3 and for 1 of 1 resident reviewed with an indwelling foley catheter (a device that drains urine from your urinary bladder into a collection bag outside of your body when you can't urinate on your own), Resident ID #4.<br><br>Findings are as follows:<br><br>According to [NAME] CoursePoint Enhanced for Taylor's Fundamentals of Nursing, 9th Edition the following are important nursing measures used to care for patients with an indwelling catheter: .make sure that the patient maintains a generous fluid intake, unless contraindicated by other health concerns. This helps prevent infection and irrigates the catheter naturally by increasing urine output .note and record the amount of urine on the patient's intake-and-output record every 8 hours .<br><br>1. Record review revealed Resident ID #3 was readmitted to the facility in August of 2024 with diagnoses including, but not limited to, urinary tract infection, anemia, and Methicillin-Resistant Staphylococcus Aureus (MRSA).<br><br>Record review of Resident ID #3's care plan reveals that s/he has a suprapubic catheter with interventions to include but are limited to, Monitor/record/report PRN [as needed] .no output .urinary frequency .<br><br>Record review failed to reveal evidence that the facility was noting and recording Resident ID #3's intake and output every 8 hours per the nursing professional standard of practice. Additional record review failed to reveal evidence that the resident's urinary frequency was being monitored per the care plan.<br><br>During a surveyor interview on 9/18/2024 at 10:30 AM with Director of Nursing Services (DNS), she acknowledged that Resident ID #3 has a suprapubic catheter. Additionally, she revealed that nursing staff does not note or record the resident's intake or output.<br><br>2. Record review revealed Resident ID #4 was readmitted to the facility in July of 2022 with diagnoses including, but not limited to, chronic kidney disease and dementia.<br><br>Record review of Resident ID #4's care plan reveals that s/he has a foley catheter with interventions to include but are limited to, Monitor/record/report to MD [medical doctor] for no output .urinary frequency .<br><br>Record review failed to reveal evidence that the facility was noting recording Resident ID #4's intake and output every 8 hours per the nursing professional standard of practice. Additional record review failed to reveal evidence that the resident's urinary frequency was being monitored per the care plan.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a surveyor interview on 9/18/2024 at approximately 3:00 PM with the DNS in presence of the Administrator and the Regional Nurse, she was unable to explain why the facility was not noting or recording the intake and output for Residents ID #s 3 and 4. |