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	11/25/2024

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 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. 37158 Based on record review and staff interview, it has been determined that the facility failed to ensure that services provided by the facility meet professional standards of quality relative to following physician's orders for 1 of 4 residents reviewed, Resident ID #3. 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 Resident ID #3 was admitted to the facility in October of 2024 with diagnoses including, but not limited to, atrial fibrillation (an irregular heartbeat often causing inadequate blood flow through the heart) and pneumonia. Record review of the hospital Continuity of Care document dated 10/31/2024 revealed a physician's order to start Cefpodoxime (a medication prescribed to treat various infections) 200 milligrams(mg) twice a day for 3 days, with a stop date of 11/3/2024. Record review of the November 2024 Medication Administration Record revealed that the Cefpodoxime was not administered as ordered on 11/1/2024, for both the morning and evening doses, and on 11/3/2024 for the evening dose, indicating that the resident missed 3 doses of the medication. During a surveyor interview on 11/20/2024 at 4:10 PM with the Unit Manager, Licensed Practical Nurse, Staff B, she was unable to explain why the resident did not receive the medication as ordered. She further revealed that there is an in house pyxis (an automated medication dispensing system) machine that contained Cefpodoxime. During a surveyor interview on 11/21/2024 at 10:38 AM with Licensed Practical Nurse, Staff C, she revealed that she was the nurse caring for the resident on 11/1/2024 and she acknowledged that she did not administer the morning or the evening doses of the Cefpodoxime to the resident, and that she did not notify the provider of the missed doses. During a surveyor interview at 11/21/2024 at approximately 12:30 PM with the Director of Nursing Services, she was unable to explain why the resident was not administered the Cefpodoxime, as ordered. (continued on next page)

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 11/21/2024 at approximately 1:30 PM with the resident's physician, he acknowledged that he was not made aware of the missed doses of the Cefpodoxime. He further revealed that he would expect if a medication was not administered that the nurse would notify the provider of the missed dose.

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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 0661 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37158 Based on record review and staff interview, it has been determined that the facility failed to reconcile all pre-discharge medications with the resident's post-discharge medications, for 1 of 3 residents reviewed who were discharged from the facility, Resident ID #1. Findings are as follows: Record review of a community reported complaint received by the Rhode Island Department of Health on 11/19/2024, alleges that Resident ID #1 was discharged home with Resident ID #2's medications. This resulted in one of the medications being taken by Resident ID #1 on two separate dates following his/her discharge. Record review for Resident ID #1 revealed s/he was admitted to the facility in October of 2024 with diagnoses including, but not limited to, liver cell carcinoma, end stage renal disease and dependence on renal dialysis (a procedure that removes waste and excess fluid from the blood when the kidneys are no longer functioning properly). Further review revealed the resident was discharged to his/her home on 11/10/2024. Record review revealed Resident ID #2 was readmitted to the facility in November of 2024 with diagnoses including, but not limited to, hyperlipidemia (high cholesterol) and hypertension (high blood pressure). Record review of Resident ID #2's physician orders revealed a current order for Atorvastatin (a medication prescribed to treat high cholesterol) 40 milligrams (mg) daily and two other medications that were discontinued on 11/6/2024, Lisinopril 40 mg and Amlodipine 2.5 mg (medications prescribed to treat high blood pressure). During a surveyor interview on 11/20/2024 at 11:48 AM with the complainant, s/he revealed that when the admitting nurse from the home care agency was reviewing Resident ID #1's medications, s/he noted 3 medications, Atorvastatin, Lisinopril and Amlodipine, included with Resident ID #1's medications, belonging to Resident ID #2. Additionally, s/he revealed that Resident ID #1 self administered the Atorvastatin 40 mg, to himself/herself on 11/11/2024 and 11/12/2024. During a surveyor interview on 11/20/2024 at 10:37 AM with Licensed Practical Nurse, Staff A, she revealed that she was part of Resident ID #1's discharge on 11/10/2024. Staff A revealed that the resident's medications were already placed in a bag prior to his/her discharge on 11/10/2024. Staff A was unsure who placed the medications in the bag prior to the resident's discharge. She acknowledged that she did not reconcile the medications that were included in the bag to ensure the resident had the correct medications. Staff A further revealed that she did not provide instructions for the medications to Resident ID #1 or his/her family member at the time of the discharge. Additionally, she revealed she placed the discharge paperwork in the bag with the resident's medications before taking the resident out to his/her car. (continued on next page)

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F 0661 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the Discharge/Transfer of Patient form for Resident ID #1 revealed a discharge date of [DATE]. Further review of the document failed to reveal evidence of any medication orders listed or any evidence that discharge medication instructions were provided to either the resident or his/her family member. Record review of the nursing progress notes failed to reveal evidence that the resident was discharged on [DATE] or that any medication teaching or instructions were provided to the resident or the resident's family member upon the resident's discharge. During a surveyor interview with the Director of Nursing Services on 11/20/2024 at approximately 11:15 AM, she was unable to explain why a medication reconciliation of all pre-discharge medications with the resident's post-discharge medications was not completed and that discharge instructions for each medication were not provided to either Resident ID #1 or his/her family member upon discharge from the facility. This facility's failure to complete medication reconciliation and provide discharge medications instructions to residents being discharged places the facility's residents at risk for serious harm, serious impairment, serious injury or death.