

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER Bannister Ctr for Rehabilitation and Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 135 Dodge Street Providence, RI 02907	

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 - 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43987</p> <p>Based on record review and staff interview, it has been determined that the facility failed to protect the residents' right to be free from abuse for 2 of 2 residents reviewed who sustained injuries as a result of a resident-to-resident altercation, Resident ID #s 1 and 3.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled, Abuse, last revised October of 2022 states in part, . The facility prohibits the . abuse of residents .by anyone .Definitions Abuse: The willful infliction of injury .or punishment resulting physical harm, pain or mental anguish .to residents .Physical abuse Includes hitting, slapping .</p> <p>1. Record review of a community reported complaint submitted to the Rhode Island Department of Health on 9/25/2024 indicates that Resident ID #1 (the victim) alleged that the Skilled Nursing Facility was aware that s/he had been threatened by Resident ID #2 (the perpetrator), resulting in Resident ID #1 being assaulted by Resident ID #2.</p> <p>Record review revealed that Resident ID #1 was admitted to the facility in September of 2024 with a diagnosis including, but not limited to, chronic multifocal osteomyelitis (bone infection) of the right ankle and foot, anxiety disorder and chronic post-traumatic stress disorder (PTSD).</p> <p>Review of Resident ID #1's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact condition.</p> <p>Record review of Resident ID #1's care plan revealed a focus area initiated on 9/26/2024 indicating the resident was a victim of a recent traumatic event related to his/her diagnosis of PTSD, with interventions including but not limited to maintaining a safe environment for his/her safety.</p> <p>Record review of a progress note dated 10/14/2024 at 8:15 PM revealed a skin check was authored by Registered Nurse (RN), Staff A, which indicated that Resident ID #1 did not have any bruises or redness to his/her face or neck.</p> <p>Further review of the progress notes dated 10/14/2024 at 8:59 PM authored by RN, Staff B, revealed that Resident ID #1 accused Resident ID #2 of hitting him/her with a commode cover on the head and face and requested to be seen at the hospital.</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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of an Emergency Department (ED) provider note dated 10/14/2024 at 9:50 PM revealed that Resident ID #1 presented to the hospital after reportedly being a victim of an assault. S/he reports that s/he was in his/her room and was assaulted by another resident who previously verbally abused her/him.</p> <p>Further review of the ED provider note revealed that the resident had a Computed Tomography (CT; a test that uses special x-ray equipment to help assess injuries) of the brain, face, and cervical spine that resulted positive for a nondisplaced right maxillary bone (right upper jaw) fracture involving lateral wall of right maxillary sinus (area near the side of the nose).</p> <p>Record review revealed that, Resident ID #2, was admitted to the facility in April of 2024 with diagnoses including, but not limited to, dementia with behavioral disturbance with behavioral disturbance.</p> <p>Record review of a psychiatric evaluation and consultation note dated 10/7/2024 revealed that nursing staff requested this consultation because of Resident ID #2's behavior. In addition, it revealed a current assessment/plan that indicated, in part, to monitor his/her mood for behavior changes or concerns, give medications as ordered and to continue with the plan of care.</p> <p>Record review of Resident ID #2's care plan initiated on 5/2/2024 revealed a focus area for behavioral problems related to agitation that includes in part, yelling, wandering into other resident's rooms, taking their belongings, history of homicidal ideation and striking out against staff and residents. Interventions include in part, to provide one on one care when needed for periods of agitation, and restlessness.</p> <p>During a surveyor interview on 10/18/2024 at 12:15 PM with Nursing Assistant (NA), Staff D, revealed that Resident ID #2 walks around the unit aimlessly and enters other residents' rooms taking their belongings. She then described Resident ID #2 as being out of control. In addition, Staff D states that Resident ID #2 requires two staff for care and that s/he is sometimes physically aggressive toward staff and would slap or scratch when while they are providing care. She further revealed that Resident ID #2 will take other residents' belongings when she/he wanders into other residents room and then attempts to slap other residents when they try to get their belongings back.</p> <p>Record review of a progress notes dated 10/15/2024 revealed the following:</p> <p>- 12:28 AM: Resident ID #2 was accused by another resident of hitting him/her on the head with a commode cover. Resident ID #2 was interviewed by two police officers but was unable to tell the story due to his/her dementia.</p> <p>- 9:42 PM: Resident ID #2 was sent out to the hospital for evaluation secondary to having a physical altercation with another resident in addition to having increased wandering behaviors including going into other residents' rooms.</p> <p>During a surveyor interview on 10/21/2024 at 1:30 PM with the Director of Nursing Services (DNS), she revealed that Resident ID #2 is not an appropriate candidate for this facility and that s/he should be in a memory care unit. Additionally, she acknowledged that that Resident ID #1 was not kept free from physical abuse.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview on 10/21/2024 at approximately 2:30 PM with the Administrator she acknowledged that Resident ID #1 was not kept free from physical abuse.</p> <p>2. Record review of a facility reported incident submitted to the Rhode Island Department of Health on 9/20/2024 alleges that (the perpetrator) Resident ID #4 entered (the victim's) Resident ID #3's room. Resident ID #3 attempted to redirect Resident ID #4 out of his/her room and Resident ID #4 refused to leave. Staff E, NA, heard the altercation and went to the room and separated the residents. Resident ID #3 was assessed, and a skin tear was noted on his/her lower lip.</p> <p>Record review revealed that Resident ID #3 was admitted to the facility in October of 2019 with a diagnosis including, but not limited to, multiple sclerosis (a chronic autoimmune disease that damages the central nervous system) and anxiety disorder.</p> <p>Review of Resident ID #3 's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, indicating intact condition.</p> <p>Record review of a progress note dated 9/20/2024 at 11:37 PM authored by Licensed Practical Nurse (LPN), Staff F, revealed that at around 9:30 PM, Resident ID #s 3 and 4 were involved in an altercation, which resulted in Resident ID #3 sustaining a bloody lip.</p> <p>Record review revealed that Resident ID #4 was admitted to the facility in September of 2024 with diagnoses including, but not limited to, dementia and delusional disorder.</p> <p>Review of Resident ID #4's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 12 out of 15, indicating moderately impaired cognition.</p> <p>Record review of a care plan revised on 9/23/2024 revealed a focus area for behavior problem related to impulsive behavior that includes in part, difficult to redirect, increased aggression, taking food from other's trays, wandering behavior, displayed aggressive behaviors towards others related striking another resident. The interventions include but are not limited to providing a program of activities.</p> <p>Record review of a progress notes dated 9/20/2024 at 11:41 PM authored by Staff F, revealed that Resident ID #4 had an altercation with another resident and was removed from his/her room and was transferred to the hospital for a psychiatric evaluation.</p> <p>Record review of a hospital discharge summary dated 9/21/2023 revealed that the resident was sent out to the hospital after punching another resident. Additionally, it revealed that the resident had been intermittently aggressive towards residents and staff in the facility.</p> <p>During a surveyor interview on 10/21/2024 at approximately 1:30 PM with the DNS, she acknowledged that that Resident ID #3 was not kept free from physical abuse and sustained an injury to his/her lip as a result of the altercation.</p>		