STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415038	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bannister Ctr for Rehabilitation and Health Care	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)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42399 Based on record review and resident and staff interviews, it has been determined that the facility failed to ensure residents are free from any significant medication errors for 1 of 3 residents reviewed for psychotropic medications, Resident ID #1. Findings are as follows: Record review of a facility reported incident submitted to the Rhode Island Department of Health on 5/21/2025 indicated a suspected misappropriation of two 0.5 milligram (mg) clonazepam pills for Resident ID #1 from the 11:00 PM - 7:00 AM shift on 5/19/2025 into the 7:00 AM to 3:00 PM shift on 5/20/2025. Review of the Federal Drug Administration's labeling/packet insert for Klonopin (clonazepam, a medication used to treat certain types of seizures and control panic attacks) states in part, .The continued use of benzodiazepines, including Klonopin, may lead to clinically significant physical dependence. The risks of dependence and withdrawal increase with longer treatment duration and higher daily dose. Abrupt discontinuation or rapid dosage reduction of Klonopin after continued use may precipitate acute withdrawal reactions, which can be life-threatening . Review of Resident ID #1's record revealed s/he was admitted to the facility in May of 2024 with diagnoses including, but not limited to, bipolar disorder and major depressive disorder. Record review of a Quarterly Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 13, indicating the resident is cognitively intact. Record review of physician's orders revealed the resident has been receiving clonazepam tablet 1 milligram (mg) twice a day for anxiety since October of 2024. Additional record review revealed a psychiatric evaluation and consultation follow up document dated 4/23/2025, which stated in part, .Discontinue Clonazapam 1 mg BID [twice daily] for anxiety. Give Clonazapam 0.5 mg BID x 14 days and reassess . Record review revealed two physician's orders, dated 5/2/2025 and 5/13/2025, for clonazepam 0.5 mg oral tablet twice daily for anxiety and to reassess the resident after 5/16/2025. Additional review revealed these orders were discontinued on 5/13/2025 and 5/16/2025. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415038	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bannister Ctr for Rehabilitation and Health Care	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)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review revealed a physician's order dated 5/19/2025 for clonazepam 0.25 mg twice daily. Record review of a progress note dated 5/16/2025 at 8:37 PM states in part, Resident inquired regarding dose of Clonazepam .educated resident the dose being D/C'd (discontinued) due to [him/her] needing to be re-evaluated . During a surveyor interview with Resident ID #1 on 5/28/2025 at 1:15 PM, s/he indicated that the week before s/he did not receive his/her clonazepam for a few days. Additionally, the resident revealed that s/he was feeling more anxious and the shaking of his/her hands had gotten worse. Record review of the May 2025 Medication Administration Record revealed that the resident did not receive any clonazepam from the evening of 5/16/2025 through 5/19/2025. During a surveyor interview with Advanced Practice Registered Nurse (APRN), Staff B, on 5/28/2025 at 3:35 PM she revealed that she was the resident's current psychiatric provider. Additionally, she revealed that the facility staff requested her to meet with Resident ID #1 on 5/20/2025, as s/he was very anxious. Record review revealed a psychiatric evaluation and consultation follow up document dated 5/20/2025, authored by, APRN, Staff B, which states in part, .Physical exam .Nursing reports that this is day two that [s/he] has not had any Klonopin and overall [s/he] is doing OK . During a surveyor interview with the Medical Director on 5/28/2025 at 2:21 PM, she revealed that she was not notified by the facility until 5/19/2025 that the resident had not had any clonazepam since 5/16/2025 and needed an order for it. She indicated that she provided the order for the resident to receive clonazepam 0.25 mg twice daily, as the staff had informed her that the resident was experiencing withdrawal symptoms. Additionally, she revealed that she was aware that the resident was on clonazepam long term and was undergoing a gradual dose reduction (GDR; is the tapering of a dose of medication to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) that was initiated by APRN, Staff C's recommendation on 5/2/2025. However, she was unclear of what Staff C's plan was for the GDR after 5/16/2025 and would have to refer to psychiatry for recommendations. During a surveyor interview with the APRN, Staff C, on 5/29/2025 at 10:29 AM, she revealed that she was previously the psych provider for Resident ID #1 and last saw him/her on 5/7/2025. She indicated that she had recommended a GDR on 4/23/2025 for the resident's clonazepam to be tapered down from 1 mg twice daily to 0.5 mg twice daily for 14 days. Additionally, she revealed she did not follow up with the resident after 5/7/2025 as she was no longer assigned to the resident's facility. Furthermore, she indicated that if she had been able to reassess the resident following the reduction of the resident's clonazepam, her plan was for the resident to remain on 0.5 mg of clonazepam twice a day. Furthermore, she revealed that the clonazepam should not be abruptly stopped because of the potential of dangerous withdrawal symptoms of that medication. During a surveyor interview with the Director of Nursing in the presence of the Administrator on 5/29/2025 at 12:33 PM, she was unable to provide evidence that the resident remained free of any significant medication errors due to the significant medication being abruptly discontinued without an appropriate GDR.