

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2024
NAME OF PROVIDER OR SUPPLIER Evergreen House Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Evergreen Drive East Providence, RI 02914	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47279</p> <p>Based on surveyor observation, record review, resident and staff interview, it has been determined that the facility failed to ensure that services being provided meet professional standards of practice relative to following a physician's order for 1 of 2 residents reviewed with diabetic ulcers and for the use of off-loading boots, Resident ID #87.</p> <p>Findings are as follows:</p> <p>According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states in part, 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.</p> <p>Record review revealed the resident was admitted to the facility in June of 2024 with diagnoses including, but not limited to, type II diabetes mellitus and non-pressure chronic ulcer of the left foot.</p> <p>Review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 15 out of 15 indicating intact cognition.</p> <p>Review of a care plan focus area dated 6/14/2024 revealed s/he is at risk for skin breakdown related to a left foot diabetic ulcer with an intervention for heel off-loading boots to bilateral feet while in bed as tolerated.</p> <p>Review of the June 2024 Treatment Administration Record revealed an order for heel off-loading boots to bilateral feet while in bed as tolerated and to check placement. Further review revealed they were signed off as in place daily.</p> <p>During surveyor observations on the following dates and times the resident was observed in bed without heel off-loading boots in place:</p> <ul style="list-style-type: none"> - 6/18/2024 at 9:38 AM - 6/20/2024 at 11:13 AM - 6/21/2024 at 1:12 PM <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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2024
NAME OF PROVIDER OR SUPPLIER Evergreen House Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Evergreen Drive East Providence, RI 02914	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview on 6/21/2024 at 1:12 PM with the resident, s/he revealed that s/he would like to wear the heel off-loading boots. Additionally, s/he revealed that staff does not ask if s/he would like to wear the boots.</p> <p>During a surveyor interview on 6/21/2024 at 1:17 PM with Licensed Practical Nurse, Staff A, she acknowledged that the resident did not have the off-loading boots in place and was initially unable to locate the boots in the room. Additionally, she acknowledged that she documented that the boots were in place although they were not.</p> <p>During a surveyor interview on 6/21/2024 at 1:29 PM with the Assistant Director of Nursing Services, she revealed that she would expect the staff to apply the off-loading boots as ordered. Additionally, she was unable to provide evidence that the facility provided services that meet professional standards relative to following physician orders.</p> <p>Cross Reference F 842</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2024
NAME OF PROVIDER OR SUPPLIER Evergreen House Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Evergreen Drive East Providence, RI 02914	
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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45263</p> <p>46241</p> <p>Based on record review, resident, and staff interview, it has been determined that the facility failed to follow their policy relative to weights. Additionally, the facility failed to ensure that residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range for 1 of 3 residents reviewed for weight loss, Resident ID #28.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled Weight measurement last revised 8/21/2023 states in part, .Notify the nurse if the weight obtained is significantly different from the prior weight [greater than or equal to] 3 lbs. [pounds] for a weekly weight; [greater than or equal to] 5 lbs. for a monthly weight .Reweigh as needed .The unit manager/designee should review and verify the weights on the day they are obtained to ensure there is no unexplained significant variance from the prior weight by utilizing the weight reports .</p> <p>Record review revealed the resident was admitted to the facility in June of 2024 with diagnoses including, but not limited to, protein-calorie malnutrition and diabetes mellitus.</p> <p>Review of a Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status score of 14 out of 15, indicating intact cognition.</p> <p>Review of the resident's care plan revealed a focus area initiated on 6/7/2024 and last revised on 6/10/2024, which revealed the resident presents with signs and symptoms of malnutrition and has potential nutrition related issues due to his/her diagnoses of diabetes mellitus and gastroparesis (a delayed emptying of gastric contents into the intestine) with a goal that states, [Resident ID #28] will not sustain any significant, unintentional weight loss through next review. An intervention includes, but is not limited to, report significant weight changes to physician.</p> <p>Review of a Nutrition assessment dated [DATE], authored by the Registered Dietitian, states in part, Malnutrition [related to] physiologic causes as evidenced by decreased appetite PTA [prior to admission], [complaint of] difficulty swallowing, weakness, muscle and fat wasting .</p> <p>Further review of the Nutrition assessment dated [DATE], revealed a summary that indicated the resident appeared frail with temporal and clavicular muscle wasting.</p> <p>Review of a document titled weight summary revealed the resident had a documented weight of 153.8 lbs. on 6/5/2024 and had a documented weight of 143 lbs. on 6/20/2024, which is a weight loss of 10.8 lbs., indicating a 7% weight loss over a 2-week period.</p> <p>Record review failed to reveal evidence that the Physician or Registered Dietitian was notified of the resident's 10.8 lbs. weight loss in a 2-week period.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2024
NAME OF PROVIDER OR SUPPLIER Evergreen House Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Evergreen Drive East Providence, RI 02914	
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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview on 6/20/2024 at 11:35 AM, with the resident, s/he revealed that s/he gets hungry at night.</p> <p>During a surveyor interview on 6/21/2024 at 10:15 AM, with the Registered Dietitian, she revealed that she was unaware of the resident's 10.8 lbs. weight loss in a two-week period and acknowledged she was not notified of the weight loss.</p> <p>Review of a progress note dated 6/21/2024 at 1:48 PM, authored by the Registered Dietitian, after the concern was brought to the facility's attention by the surveyor, states, Resident reports [s/he] would like larger portions of food at all meals. Recommend: Amend diet order to include 'double portions of protein'.</p> <p>During a surveyor interview on 6/24/2024 at 10:08 AM, with the Assistant Director of Nursing Services, she acknowledged the resident's 10.8 lbs. weight loss in a two-week period and indicated the facility's weight loss policy was not followed. Additionally, she failed to provide evidence that the resident maintained acceptable parameters of nutritional status, such as usual body weight.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2024
NAME OF PROVIDER OR SUPPLIER Evergreen House Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Evergreen Drive East Providence, RI 02914	

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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45263</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that food is stored, prepared, distributed, and served in accordance with professional standards for food service safety, relative to the main kitchen.</p> <p>Findings are as follows:</p> <p>1. Record review of a product label, Vital Cuisine Mightyshakes reads in part, .store frozen. Use thawed product within 14 days .</p> <p>During a surveyor observation on 6/18/2024 at approximately 8:30 AM, of the walk-in refrigerator unit of the main kitchen, 3 cases of Mightyshakes were observed without a date indicating when they were placed in the refrigerator unit for thawing.</p> <p>During a surveyor interview on 6/18/2024 at approximately 11:30 AM with the Food Service Director (FSD), she acknowledged that the dietary staff failed to date the product when placed in the refrigerator unit for thawing.</p> <p>2. Record review of the RI Food Code 2018 Edition 8-201.14 Contents of a HACCP (Hazard Analysis and Critical Control Points) Plan reads in part, .TIME/TEMPERATURE CONTROL FOR SAFETY FOODS [food prepared from ingredients at room temperature must be cooled to 41 degrees Fahrenheit (F) or lower within 4 hours], such as salads .follow a flow diagram by specific FOOD identifying CRITICAL CONTROL POINTS [monitoring temperature for food safety over a period of time] .</p> <p>During a surveyor observation on 6/20/2024 at approximately 2:00 PM, revealed chicken salad in a steam table pan, that was sitting on a work table at room temperature in the main kitchen.</p> <p>During a surveyor observation and interview on 6/20/2024 at approximately 2:05 PM, when the FSD was asked for a temperature reading of the chicken salad, the reading was observed at 70 degrees F.</p> <p>During a surveyor interview on 6/20/2024 at approximately 3:00 PM, with the FSD, she revealed that the staff failed to follow policy regarding the taking and recording of the temperature of the chicken salad and following a HCAPP plan.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2024
NAME OF PROVIDER OR SUPPLIER Evergreen House Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Evergreen Drive East Providence, RI 02914	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>47279</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain medical records that are accurately documented in accordance with professional standards and practices for 1 of 8 residents reviewed whose medications were reconciled following the medication administration task, Resident ID #40, and 1 of 2 residents reviewed with diabetic foot wounds requiring offloading boots, Resident ID #87.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled, Administration of Medications last reviewed on 8/24/2023, states in part, . Staff who are responsible for medication administration will adhere to the 10 Rights of Medication Administration .6. Right Documentation. Make sure to write the time and any remarks on the chart correctly. Medication administrations should be documented timely following the administration to the resident .</p> <p>1. Record review revealed Resident ID #40 was admitted to the facility in October of 2013 with a diagnosis including, but not limited to, heart failure.</p> <p>Record review revealed the resident has the following physician orders:</p> <ul style="list-style-type: none"> - Bumex 1 milligram give 1 tablet daily between 8:00 AM - 11:00 AM for congestive heart failure - Fluticasone Propionate Nasal Suspension 50 micrograms per actuation give 2 sprays in both nostrils daily between 8:00 AM - 11:00 AM for allergies <p>During a surveyor observation during the medication administration task on 6/21/2024 at 9:29 AM with Licensed Practical Nurse, Staff B, she provided the nasal spray to the resident to self-administer, however the resident indicated it was empty. Additionally, Staff B failed to administer the Bumex.</p> <p>Record review of the June 2024 Medication Administration Record revealed Staff B had signed off the above medications as administered on 6/21/2024.</p> <p>During a surveyor interview on 6/21/2024 at 12:08 PM with Staff B, she revealed that she had not administered Bumex to the resident and indicated that the resident did not receive his/her Fluticasone or Bumex as ordered. She further revealed that she should not have documented the medications as being administered if they were not administered as ordered to the resident.</p> <p>2. Record review revealed Resident ID #87 was admitted to the facility in June of 2024 with diagnoses including, but not limited to, type II diabetes mellitus and non-pressure chronic ulcer of the left foot.</p> <p>Review of a physician's order revealed to apply heel off-loading boots to his/her bilateral feet while in bed as tolerated and to check placement.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2024
NAME OF PROVIDER OR SUPPLIER Evergreen House Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Evergreen Drive East Providence, RI 02914	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During surveyor observations on the following dates and times the resident was observed in bed without heel off-loading boots in place:</p> <ul style="list-style-type: none"> - 6/18/2024 at 9:38 AM - 6/20/2024 at 11:13 AM - 6/21/2024 at 1:12 PM <p>Review of the June 2024 Treatment Administration Record revealed the order was documented as completed from 6/5 through 6/21/2024. Further review revealed the order was signed off as completed on 6/21/2024 by Licensed Practical Nurse, Staff A.</p> <p>During a surveyor interview on 6/21/2024 at 1:17 PM with Staff A, she acknowledged that the resident did not have the off-loading boots in place. Additionally, she acknowledged that she documented that the offloading-boots were in place although they were not.</p> <p>During a surveyor interview on 6/21/2024 at 1:29 PM with the Assistant Director of Nursing Services, she revealed that she would expect the staff to be following the physician orders and accurately documenting.</p> <p>Cross Reference F 658</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2024
NAME OF PROVIDER OR SUPPLIER Evergreen House Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Evergreen Drive East Providence, RI 02914	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>45263</p> <p>46715</p> <p>50004</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain an infection prevention and control program (IPCP) to help prevent the transmission of communicable diseases and infections for 2 of 2 residents reviewed for contact precautions, Resident ID #s 32 and 64. Additionally, the facility failed to conduct appropriate infection control practices relative to the storage of a nebulizer mask for 1 of 1 resident reviewed with a nebulizer machine (a device for producing a fine spray of liquid, used for inhaling a medicinal drug), Resident ID #12.</p> <p>Findings are as follows:</p> <p>Review of the Centers for Disease Control and Prevention's (CDC) document titled, Contact Precautions states in part, .Providers and staff must also .Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit .</p> <p>Review of a facility policy titled Contact Precautions states in part, .Contact Precautions-Intended to prevent transmission of pathogens that are spread by direct or indirect contact with the resident or environment . requires the use of appropriate PPE [Personal Protective Equipment], including a gown and gloves before or upon entering the room .Contact precautions are also used in situations when a resident is experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and suggest an increased potential for extensive environment contamination and risk of transmission of a pathogen, even before specific organism has been identified .</p> <p>1a) Record review revealed that Resident ID #32 was admitted to the facility in January of 2024 with a diagnosis including, but not limited to, Parkinson's Disease.</p> <p>Review of a Physician's order dated 6/17/2024 states in part, .Isolation: Contact Precautions Diagnosis: Vomit .</p> <p>During a surveyor observation on 6/18/2024 at 11:38 AM of the resident's room revealed a sign for contact precautions. The sign states in part, Everyone must put on gloves before room entry .put on a gown before room entry .</p> <p>During a surveyor observation on 6/18/2024 at 11:43 AM of Housekeeper, Staff C, she was observed in the resident's room washing the floor and speaking with the resident without wearing a gown.</p> <p>During a surveyor interview on 6/18/2024 at 11:46 AM with Staff C, she acknowledged that she should have worn a gown as required as the resident is on contact precautions.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2024
NAME OF PROVIDER OR SUPPLIER Evergreen House Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Evergreen Drive East Providence, RI 02914	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview immediately following the above observation on 6/18/2024 at 11:48 AM with Licensed Practical Nurse, Staff D, she acknowledged that the housekeeper should have worn a gown to enter the resident's room as required. Additionally, she acknowledged the resident was on contact precautions for vomiting.</p> <p>During a surveyor interview on 6/20/2024 at 10:06 AM with the Assistant Director of Nursing Services (ADNS), she revealed that the resident was on contact precautions for vomiting and would expect staff to wear a gown when entering the resident's room.</p> <p>1b) Record review revealed that Resident ID #64 was readmitted to the facility in June of 2024 with a diagnosis including, but not limited to, parainfluenza (a group of viruses that cause common respiratory infections. It is a very contagious type of viral respiratory infection caused by any of the 4 kinds of human parainfluenza viruses).</p> <p>Review of a hospital document dated 6/12/2024, titled Hospital Course, states in part, .+[positive] parainfluenza .</p> <p>Review of a progress note dated 6/17/2024 states in part, .patient continues on precautions for +flu .patient complaints of slight cough .</p> <p>During a surveyor observation on 6/18/2024 at 11:10 AM of the resident's room revealed a sign for contact precautions. The sign states in part, Everyone must put on gloves before room entry .put on a gown before room entry .</p> <p>During a surveyor observation on 6/18/2024 at 11:10 AM of Nursing Assistant, Staff E, in the presence of LPN, Staff F, she entered the resident's room without wearing a gown or gloves.</p> <p>During a surveyor interview immediately following the above observation on 6/18/2024 with Staff E, in the presence of Staff F, she acknowledged that she entered the resident's room to answer his/her call light and to deliver a drink without wearing a gown and gloves as required. Additionally, she revealed that she was unaware of why the resident was on contact precautions. Additionally, Staff F revealed that the resident was on contact precautions related to positive influenza. She further acknowledged that staff are to wear a gown and gloves when entering the room.</p> <p>During a surveyor interview on 6/20/2024 at 10:06 AM with the ADNS, she revealed that the resident was on contact precautions for parainfluenza and would expect staff to wear a gown and gloves when entering the resident's room.</p> <p>2. Review of a document from the National Heart, Lung and Blood Institute, titled How to use a Nebulizer states in part, .Between uses: Store nebulizer parts in a dry, clean plastic storage bag .</p> <p>Record review revealed that Resident ID #12 was readmitted to the facility in June of 2024 with a diagnosis including, but not limited to, chronic obstructive pulmonary disease.</p> <p>Review of a physician's order dated 6/18/2024 revealed the resident has an order for a nebulizer treatment as needed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2024
NAME OF PROVIDER OR SUPPLIER Evergreen House Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Evergreen Drive East Providence, RI 02914	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During surveyor observations on the following dates and times the resident's nebulizer mask was observed on the resident's bed, and not in a plastic bag.</p> <ul style="list-style-type: none"> - 6/18/2024 at 10:13 AM - 6/20/2024 at 2:00 PM - 6/21/2024 at 8:42 AM - 6/24/2024 at 11:38 AM <p>During a surveyor interview following the above observation on 6/24/2024 at 11:38 AM with LPN, Staff G, she acknowledged that the mask was on the bed and was not in a bag. She further revealed that the nebulizer mask should be placed in a bag after the treatment is provided to the resident.</p> <p>During a surveyor interview on 6/24/2024 at 11:53 AM with the ADNS, she revealed that the nebulizer mask should be bagged following the treatment by staff. Additionally, she was unable to provide evidence that the facility maintained an infection prevention and control program to help prevent the transmission of communicable diseases and infections.</p>		