STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415059	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard View Manor	135 Tripps Lane East Providence, RI 02915

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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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 45855 Based on record review and staff, and resident interview, it has been determined that the facility failed to post the results of the most recent survey in a readily accessible area for the residents, staff, and public. Findings are as follows: During the resident council task on 6/24/2024 at 12:37 PM, the residents stated that they were aware of the State Inspection results but stated concerns about having to access to it. During a surveyor observation on 6/25/2024 at 10:00 AM, a sign near the front desk states Department of Health Survey Book Available Upon Request in Receptionist office. Review of the facility's survey results binder revealed that the last entry was from a survey conducted in December of 2023, and did not include the most recent survey results from April of 2024. During a surveyor interview with the Regional Director of Clinical Services on 6/25/2024 at 4:38 PM, she revealed that the binder was not updated to include the most recent surveys for the year of 2024. She further indicated that the survey results binder should be updated and placed in a readily accessible location.

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 46118 43987 Based on record review and staff interview it has been determined that the facility failed to keep a resident free from physical abuse for 1 of 3 residents reviewed, Resident ID #45. Findings are as follows: According to State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, last revised 2/2023, .Abuse is the willful infliction of injury .with resulting physical harm, pain or mental anguish .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain .Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . Resident to Resident Abuse of Any Type A resident to resident altercation should be reviewed as a potential situation of abuse .Also, when investigating an allegation of abuse between residents, the surveyor should not automatically assume that abuse did not occur, especially in cases where either or both residents have a cognitive impairment or mental disorder. Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions. In determining whether F 600-Free from Abuse and Neglect should be cited in these situations, it is important to remember that abuse includes the term 'willful'. The word 'willful' means that the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. An example of a deliberate (willful) action would be a cognitively impaired resident who strikes out at a resident within his/her reach .The facility may provide evidence that it completed a resident assessment and provided care planning interventions to address a resident's distressed behaviors such as physical, sexual or verbal aggression. However, based on the presence of resident to resident altercations, if the facility did not evaluate the effectiveness of the interventions and staff did not provide immediate interventions to assure the safety of residents, then the facility did not provide sufficient protection to prevent resident to resident abuse. For example, redirection alone is not a sufficiently protective response to a resident who will not be deterred from targeting other residents for abuse once he/she has been redirected . Record review of a facility incident report to the Rhode Island Department of Health on 6/11/2024, stated that the alleged perpetrator, Resident ID #81, was found over Resident ID #45 biting his/her cheek. Record review revealed that Resident ID #45, the alleged victim, was admitted to the facility in May of 2023 with diagnoses including, but not limited to, dementia without behavioral disturbances and anxiety. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) Assessment for Resident ID #45 dated 5/29/2024, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating that the resident's cognition was intact. Record review of Resident ID #45's progress notes revealed a Social Service note dated 6/11/2024, authored by the Director of Social Services (DSS), Staff B, which revealed in part, .When, prompted about the incident. [Resident ID #45] reported .'my roommate got up, sat on my bed, and bit me on my face' . [s/he]showed the DSS the mark on [his/her] face . Record review revealed that Resident ID #81, the alleged perpetrator, was admitted to the facility in November of 2021 with diagnoses including, but not limited to, anxiety and major depression. Review of a Quarterly MDS for Resident ID #81 dated 4/28/2024, revealed a BIMS score of 11 out of 15, indicating that the resident's cognition was moderately impaired. Review of Resident ID #81's care plan dated 12/6/2021 revealed the resident exhibited behavioral problems including, but not limited to, swearing, agitation, and combativeness. Further review revealed an intervention to provide immediate safety for the residents and others. Record review of a progress note dated 6/11/2024 for Resident ID #81, reveals in part, Around 12:10 am, staffs [were heard] screaming and yelling. When writer arrived in the resident's room, resident [ID #81] was sitting on [his/her] roommate's bed slapping on [his/her] roommate's face [Resident ID #45], swearing at [him/her]. [Resident ID #45] kept saying [Resident ID #81] bit me on my face .When asked resident [ID #81] what happened [s/he] reply: I wanted the lights off and [s/he] yelled at me, I bit [his/her] face and I had enough of [him/her]. Record review of an investigation statement authored by Nursing Assistant (NA) Staff G, dated 6/11/2024, states in part, .the nurse came and when we both removed them from each other but [Resident ID #81] .was still trying to hit [Resident ID#45] .we then moved [Resident ID #45] .to another room . Record review of an investigation statement authored by Licensed Practical Nurse, Staff R, dated 6/11/2024, states in part, .When writer arrived there found [NA] removing [him/her] roommate [Resident ID #81] away from the resident [ID #45]. While we were trying to separate them [Resident ID #81] still tried to hit [Resident ID #45] . Record review for Resident ID #45 revealed a telehealth evaluation dated 6/11/2024 at 5:15 AM, authored by a doctor of osteopathic medicine, Staff A, revealed in part, .[Resident ID #45] post assaulted by roommate and was bitten on face per nurse around 1230am .Patient initially c/o [complaint of] pain but now has no pain .Exam findings per nurse and video observation .skin: right cheek, mod [moderately] pink redness, bite marks .start Moxifloxacin [antibiotic] 400 mg [milligrams] PO [by mouth] daily x 7 days RE: [related to] human bite injury . Right cheek bite injury: cleanse, pat dry and apply topical antibiotics daily x 7 days . Surveyor observation of Resident ID #45, on 6/26/2024 at 1:25 PM revealed a purple discoloration was noted on the upper area of Resident ID #45's right cheek. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview immediately following the above observation, the resident revealed that s/he remembers the incident and indicated that the perpetrator was his/her roommate. The resident indicated that the perpetrator attacked him/her while s/he was in bed. The resident further indicated that s/he had pain to his/her cheek for a week following the incident and that it was treated. Additionally, the resident indicated that s/he felt strongly that this attack was abuse. During a surveyor interview on 6/26/2024 at 3:34 PM with Director of Nursing Services, she acknowledged that Resident ID #45 was assaulted by his/her roommate and that s/he sustained a bite to his/her face. Additionally, she was unable to provide evidence that the facility kept Resident ID #45 free from abuse.

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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. 46118 37158 Based on record review 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 physicians orders for 2 of 4 residents reviewed relative to obtaining weekly weights, Resident ID #s 53 and 96. 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 . 1. Record review revealed Resident ID #53 was readmitted to the facility in May of 2024 with diagnoses including, but not limited to, dysphagia and severe protein calorie malnutrition. Record review revealed a physician's order dated 5/2/2024 with a start date of 5/6/2024 for weekly weights. Record review of the documented weights revealed the following: 5/7/2024 123.4 lbs. (pounds) 5/14/2024 not obtained 5/21/2024 not obtained 5/27/2024 123.3 lbs. 6/3/2024 not obtained Record review of the nursing progress note dated 5/14/2024 revealed the weight was unable to be obtained as ordered, without any further indication as to why. During a surveyor interview on 6/26/2024 at 3:46 PM with the Director of Nursing Services (DNS), she was unable to explain what was meant by the documentation that his/her weight was unable to be obtained. The DNS revealed she would expect that the nurse would indicate why the resident's weight was not obtained and an additional attempt would be made to obtain the resident's weight at a later time. Additionally, she was unable to provide evidence of the resident's weekly weights for the weeks of 5/14/2024, 5/21/2024 and 6/3/2024. 2. Record review revealed Resident ID #96 was readmitted to the facility in May of 2024 with diagnoses including, but not limited to, weakness and diabetes mellitus. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed a physician's order dated 5/12/2024 with a start date of 5/13/2024 to obtain a weight on admission and weekly weights for 4 consecutive weeks post admission, then reassess. Record review of the documented weights revealed the following: 5/20/2024 111.4 lbs. 5/27/2024 106.4 lbs. 6/3/2024 104.8 lbs. 6/10/2024 not obtained 6/17/2024 not obtained 6/25/2024 109.2 lbs. During a surveyor interview on 6/26/2024 at 3:46 PM with the DNS, she was unable to provide evidence of the missing weekly weights for 6/10/2024 and 6/17/2024. Additionally, she indicated that she would have expected staff to have followed the physicians orders to obtain the weights.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46118 Based on record review and staff interview it has been determined that the facility failed to provide treatment and care in accordance with professional standards of practice for 1 of 1 resident reviewed with a history of a deep vein thrombosis (DVT), Resident ID # 36. Findings are as follows: According to Nursing Health Assessment: A clinical Judgement Approach 4th edition, 2023 published by Wolters Kluwer, it has been revealed that characteristics of a Deep Vein Thrombosis, (DVT) also known as a blood clot, include, but are not limited to, pain and swelling at the site. Review of the facility policy titled, Condition: Significant Change states in part, .Staff will communicate with the physician .regarding changes in condition to provide timely communication of resident/patient status change which is essential to quality care management . Record review revealed Resident ID #36 was readmitted to the facility in May of 2024 with a diagnosis including, but not limited to, acute embolism and thrombosis of deep veins of the right lower extremity. 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. During a surveyor interview on 6/24/2024 at 9:42 AM with Resident ID #36, s/he indicated that his/her left leg was red and warm. The resident further indicated that the nursing staff were aware and that s/he recently had a hematoma in his/her right leg, that is now an open wound. Record review revealed the following progress notes: 6/22/2024 at 10:19 PM- The resident stated that s/he was experiencing a new onset of increased pain to his/her left lower leg.history of DVT and hematoma that required surgical intervention. LLE [left lower extremity] noted with redness and edema .Patient reports 10/10 pain. Endorsed to oncoming nurse patient's symptoms and complaints. 6/23/2024 at 8:24 AM- Patient stated pain is excruciating/radiating and unbearable .medicated patient with prn [as needed] Percocet [pain medication]. Patient LLE noted with edema on outer L [left] side mild discoloration and warmth. Reported to MD with new orders for STAT [as soon as possible] Venous Doppler [ultrasound], Stat labs .and UA [urinalysis] to rule out sepsis . 6/23/2024 at 3:33 PM- .Awaiting .Venous Doppler .continues to endorse pain from LLE . Record review revealed a physician's order dated 6/23/2024 at 7:32 AM for a STAT venous doppler. Further review failed to reveal evidence that a provider was notified that the Venous Doppler had not been completed as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review failed to reveal evidence that a provider was notified of the change in condition on 6/22/2024 until the next morning, on 6/23/2024. During a surveyor interview on 6/26/2024 at 10:55 AM with Licensed Practical Nurse (LPN) Staff C, she indicated that the venous doppler had not yet been completed as ordered at that time. She further indicated that the order had not been transcribed as STAT. Additionally, she could not provide evidence that a provider was notified on 6/22/2024 of the change in condition or that the venous doppler had not yet been completed as ordered. During a surveyor interview on 6/26/2024 at 11:18 AM with Nurse Practitioner, Staff D, she indicated that she was made aware of the resident's change in condition on 6/24/2024, however was unaware that the venous doppler had not been completed as ordered. She further indicated that she would have expected nursing to notify a provider that it had not been completed as ordered. Additionally, she indicated that due to the resident's history of a DVT, the resident needed to be sent to the hospital for an evaluation immediately. During a surveyor interview on 6/26/2024 at 12:57 PM with the Medical Director, he indicated that he would expect a STAT order to be completed the day it was ordered. He further indicated that he would expect a provider to be notified of a change in condition and if an order was not completed. Additionally, he indicated that the resident should be sent to the hospital for an evaluation if a STAT venous doppler could not be completed timely at the facility. During a surveyor interview on 6/26/2024 at 11:46 AM with the Director of Nursing Services, she acknowledged that the STAT venous doppler that was ordered on 6/23/2024 had not been completed as ordered or that the physician had been notified that it was not completed, until after the surveyor brought it to the facility's attention. She further indicated that the resident was being sent to the emergency department to obtain a venous doppler immediately. Additional record review revealed that, while at the emergency department, the resident was found to have a small complex fluid collection in the calf which is likely a hematoma or possibly a small abscess.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 46118 49184 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide necessary treatment and services, consistent with professional standards of practice, to promote wound healing and prevent new ulcers from developing for 1 of 3 residents reviewed for pressure ulcers (a localized injury to the skin or underlying tissue due to pressure), Resident ID #42. Findings are as follows: Record review revealed Resident ID #42 was admitted to the facility in January of 2023 with diagnoses including, but not limited to, Alzheimer's disease, and pressure ulcers to the coccyx (tail bone), and left heel. Record review revealed a physician's treatment order dated 6/14/2024 which states in part, .Skin prep periwound [area around the wound]. Apply medihoney f/b [follwed-by] calcium alginate [an absorbent dressing] and cover with foam dressing .Location: left heel every evening shift . Record review revealed a physician's treatment order dated 6/19/2024 which states .Pat dry. Apply medihoney and bordered foam dressing .Location: coccyx [every] evening shift . During a surveyor observation of the wounds on 6/26/2024 at 11:17 AM with Licensed Practical Nurse (LPN), Staff E, revealed the resident had two dressings dated 6/24/2024; one covering his/her coccyx, and one covering his/her left heel. Additional observation of the wound care revealed Staff E removed a soiled dressing from the coccyx, cleansed wound area with normal saline, and applied barrier cream to the wound rather than the medihoney as ordered. Staff E then exited the room and failed to cover the coccyx wound with the bordered foam dressing as ordered. During a surveyor interview on 6/26/2024 at 11:23 AM, with the Infection Preventionist, s/he revealed that the resident's wound treatments should be completed daily as ordered. Additionally, s/he would expect the wound dressings to be completed as ordered. During a surveyor interview on 6/26/2024 at 12:22 PM, with Staff E, she indicated that she was uncertain of the order prior to providing the wound care to Resident ID #42. Additionally, Staff E acknowledged the wound dressings she removed from the resident were dated 6/24/2024, indicating that the dressings had not been completed daily as ordered. During a surveyor interview on 6/26/2024 at 12:30 PM, with the Director of Nursing Services, she indicated that she would expect the physician's orders to be followed. 43987

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 46118 Based on record review and staff interview, it has been determined that the facility failed to ensure that residents who require dialysis (a blood purifying treatment given when kidney function is not optimum) receive such services consistent with professional standards of practice for 1 of 1 resident reviewed for dialysis, Resident ID #36. Findings are as follows: Review of the facility policy titled Hemodialysis states in part, .To provide comprehensive care to residents/patients .Communication between the facility and the hemodialysis center will occur using a communication book/sheet that consists of .Any change of condition from last hemodialysis treatment . Record review revealed Resident ID #36 was readmitted to the facility in May of 2024 with diagnoses including, but not limited to, acute kidney failure and chronic kidney disease, stage 4 (severe). Record review of a care plan last revised on 6/3/2024 revealed, the resident has a diagnosis of chronic kidney disease and started on dialysis. Further review revealed an intervention including, but not limited to, monitor lab work as ordered by the physician. Record review revealed the resident receives hemodialysis three times a week at a dialysis center. Record review revealed a physician's order dated 6/23/2024 for STAT (as soon possible) labs. Record review of the lab results dated 6/23/2024 revealed a critically low potassium level of 3.0 milliequivalents per liter (mEq/L; normal range 3.5-5.4 mEq/L). Record review revealed the physician was notified of the critically low potassium level on 6/23/2024. Further review revealed a physician's order dated 6/23/2024 for a STAT dose of potassium due to the critical level. Review of a Nurse Practitioner's (NP) note dated 6/24/2024 revealed, NP reviewed labs. Contact nephrology [a medical professional who specializes in kidney function] for hypokalemia [low potassium level] management ASAP [as soon as possible] given dialysis status. Review of the Hemodialysis Communication Sheet dated 6/25/2024 failed to reveal evidence that the resident's critical lab values and change of condition was communicated to the dialysis center or nephrology. Review of lab results dated 6/26/2024 revealed a potassium level of 3.3 mEq/L, indicating continued hypokalemia. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 6/26/2024 at 1:18 PM with Licensed Practical Nurse, Staff C, she indicated that the nursing staff are responsible for communicating with dialysis via the communication sheet. She further indicated that she completed the communication sheet dated 6/25/2024 and did not include the resident's potassium level because she was unaware of the resident's lab results or of the NP's progress note. Additionally, Staff C contacted the dialysis center at that time and was informed that nephrology had not been made aware of the resident's critically low potassium level until just prior to her call. During a surveyor interview on 6/26/2024 at 1:45 PM with the Director of Nursing Services, she could not provide evidence that the facility effectively communicated the resident's critically low potassium level to the dialysis center prior to the surveyor bringing it to the facility's attention.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 45855 Based on record review and staff interview, it has been determined that the facility failed to complete an annual performance review for every nurse aide (nursing assistant; NA), at least once every 12 months, for 4 of 7 NA personnel records reviewed, Staff F, G, H, I. Findings are as follows: Record review of the personnel files failed to reveal evidence that an annual performance evaluation was completed for the following NAs: -Staff F, Date of hire 11/18/2022 -Staff G, Date of hire 1/21/2020 -Staff H, Date of hire 1/30/2013 -Staff I, Date of hire 9/22/2020 During a surveyor interview with the Director of Nursing Services on 6/26/2024 at 10:45 AM, she was unable to provide evidence of a completed performance evaluation within the last 12 months for the above-mentioned employees.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 46118 43987 Based on record review and staff interview, it has been determined that the facility failed to address pharmacy recommendations in a timely manner for 2 of 5 residents reviewed for unnecessary medications. Resident ID #s 22 and 97. Findings are as follows: Record review of the facility policy titled, Drug Regimen Review-Monthly states in part, .The attending Physician or licensed designee shall respond to the Drug Regimen Review within 7-14 days or more promptly, whenever possible . 1a. Review of the 4/9/2024 pharmacy recommendations for Resident ID #22 revealed a recommendation to reduce the resident's Pravastatin (a medication used to treat high cholesterol) from 20 milligrams (mg) to 10 mg. Additionally, it revealed that the recommendation was not signed by the provider until 6/20/2024. In addition, the recommendation had not been implemented until it was brought to the facility's attention by the surveyor, indicating that it had been over 2 months since the recommendation was made. 1 b. Review of the 6/10/2024 pharmacy recommendations for Resident ID #22 revealed a recommendation to conduct a trial discontinuation of Risperdal (an antipsychotic medication) 0.25 mg. The recommendation was signed by the physician on 6/11/2024, however was not implemented. 2. Review of the 5/9/2024 pharmacy recommendation for Resident ID #97 revealed a recommendation to obtain a Valproic Acid (VPA; Valproic Acid is medication used to treat seizures and psychiatric conditions) serum (blood) level within two weeks and then every 6 months (blood levels of VPA must stay within a specific range for the drug to work effectively and to monitor for toxic levels). Further review revealed the recommendation was signed by the physician on 6/11/2024. Record review revealed the VPA level was not obtained until 6/26/2024, after it was brought to the facility's attention by the surveyor on 6/25/2024. Review of the lab report dated 6/26/2024 revealed a VPA level of 19.8 micrograms (MCG)/milliliters(ML). Further review revealed the therapeutic level is 50-125 MCG/ML indicating a subtherapeutic level. During a surveyor interview on 6/25/2024 at 5:08 PM with the Director of Nursing Services, she acknowledged that the pharmacy recommendations for Resident ID #s 22 and 97 had not been completed prior to the surveyor bringing it to the facility's attention. Additionally, she indicated that she would expect all pharmacy recommendations to be completed within 14 days per the facility's policy.

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	415059	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard View Manor	135 Tripps Lane East Providence, RI 02915

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46118 42399 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to prepare, store, and distribute food according to professional standards of food service safety, relative to the main kitchen and 3 of 4 nourishment areas observed. Findings are as follows: 1a. Review of the Rhode Island Food Code, 2018 Edition, section ,d+[DATE].11 states in part, (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch . During the initial tour of the main kitchen with the [NAME] Supervisor on [DATE] at 8:45 AM, the following was observed: - One of three chef's knives with dried brown food matter on the blade - The blade of the countertop can opener was covered in a black, sticky residue During a surveyor interview with the [NAME] Supervisor immediately following the above observation, she acknowledged that the above items were dirty and needed to be cleaned. 1b. Review of the Rhode Island Food Code, 2018 Edition, section ,d+[DATE].17 states in part, .(B) . refrigerated, ready-to-eat time/temperature control for safety food .shall be clearly marked, at the time the original container is opened in a food establishment .and: (1) the day the original container is opened in the food establishment shall be counted as Day1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date . During a surveyor observation of the reach-in refrigerator in the main kitchen on [DATE] at approximately 9:00 AM, the following was observed: - 12 four ounce (oz) plastic cups with what appeared to be applesauce, not labeled or dated - 18 four oz plastic cups with what appeared to be mixed fruit, not labeled or dated During a surveyor interview with the [NAME] Supervisor immediately following the above observation, she acknowledged that the above foods should be labeled and dated. 1c. Review of the Rhode Island Food Code, 2018 Edition, section ,d+[DATE].11 states in part, .Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, and linens . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During surveyor observations of Dietary Aide, Staff J, in the main kitchen on [DATE] at 8:45 AM and 10:55 AM, he was handling food and equipment without a beard restraint. During a surveyor observation of Cook, Staff K, in the main kitchen on [DATE] at 10:55 AM, he was at the stove preparing the lunch meal without wearing a beard restraint. During a surveyor interview with the [NAME] Supervisor immediately following the above observations, she acknowledged that Staff J and K should have been wearing beard coverings while working in the main kitchen. 2. Review of the Rhode Island Food Code, 2018 Edition, section ,d+[DATE].17 states in part, .(B) . refrigerated, ready-to-eat time/temperature control for safety food .shall be clearly marked, at the time the original container is opened in a food establishment .and: (1) the day the original container is opened in the food establishment shall be counted as Day1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date . Review of the Rhode Island Food Code, 2018 Edition, section ,d+[DATE].11 states in part, (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch . Record review of a facility policy titled, Use & Storage of Food Brought In By Family or Visitors, last revised [DATE] states in part, .All food items that are already prepared by the family or visitor brought in, must be labeled with content and date. The facility may refrigerate, label and date prepared items in the nourishment refrigerator. The prepared food must be consumed by the resident within 3 days. If not consumed within 3 days, food will be thrown away by facility staff . 2 a. During a surveyor observation of the A Unit nourishment area on [DATE] at 11:15 AM, the following was observed: - Dried brown food debris was stuck to the top of the toaster - In the refrigerator, there were two 46 oz containers of honey thickened lemon flavored water, open and not dated. There was one 46 oz container of nectar thickened lemon flavored water, open, not dated, and missing the cap. Manufacturer's instructions indicate the product is to be used within 7 days after opening. During a surveyor interview with Licensed Practical Nurse (LPN), Staff L, immediately following the above observation, she acknowledged that the toaster was dirty and that the thickened beverages should have been dated when opened. 2 b. During a surveyor observation of the B Unit nourishment area on [DATE] at approximately 11:20 AM, the following was observed in the refrigerator: - One 46 oz container of nectar thickened lemon flavored water, open and not dated. - A plastic store bought container with sliced strawberries and blueberries, not labeled or dated. - A brown paper bag containing unidentified food items, labeled [resident name] 11A, without a date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- A cheeseburger covered in plastic wrap, not labeled or dated. - Four burger patties covered in plastic wrap, not labeled or dated. - An unidentified food item wrapped in foil, marked C, not labeled or dated. - 2 paper bowls taped together with unidentified food items inside, labeled 11A, without a date. - Another small brown paper bag containing unidentified food items, labeled 11A, without a date. - 1 vanilla and 2 strawberry-flavored four oz [NAME] Readycare shakes with a use-by date of [DATE]. During a surveyor interview with LPN, Staff C, immediately following the above observations, she acknowledged that the above food and beverage items were not labeled or dated correctly and that the shakes should have been discarded, as they were past their use-by date. 2 c. During a surveyor observation of the C Unit nourishment area on [DATE] at 11:40 AM, the following was observed in the refrigerator: - One 46 oz container of nectar thickened lemon flavored water, opened and not dated. - A rectangular glass storage container with orange colored food inside, labeled ,d+[DATE]. - A black, round takeout container with rice, vegetables and meat, labeled ,d+[DATE]. - A plastic, quart sized container of chicken noodle soup labeled 18B [DATE]. - 2 strawberry flavored, four oz [NAME] Readycare shakes with a use-by date of [DATE]. During a surveyor interview with Nursing Assistant, Staff M, immediately following the above observation, she acknowledged that the above food and beverage items were not labeled or dated correctly and that the shakes should have been discarded, as they were past their use-by date. During a surveyor interview with the Registered Dietitian and [NAME] Supervisor on [DATE] at 12:15 PM, they indicated they would expect all food and beverages to be dated when opened, expired foods to be discarded, food equipment to be clean, all employees to wear appropriate hair coverings, and that nourishment area refrigerators are maintained in accordance with the facility's policy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 43987 45855 37158 46118 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 to help prevent the transmission of communicable diseases and infections due to the facility's failure to utilize appropriate Enhanced Barrier Precautions (EBP) (an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs] in nursing homes), for 4 of 8 residents reviewed, Resident ID #s 84, 28, 42, and 163. Additionally, the facility failed to conduct appropriate infection control practices relative to the handling of soiled linen. Findings are as follows: Record review of the facility policy titled Enhanced Barrier Precautions Policy states in part, .implement enhanced barrier precautions for preventing transmission of novel or targeted multidrug-resistant organisms . MDROs are organisms that are resistant to all or most antibiotics .MRDOs may include, but are not limited to: Methicillin-resistant Staphylococcus aureus (MRSA) .ESBL [Extended Spectrum Beta Lactimase] . Enhanced Barrier Precautions require the use of gown and gloves for certain residents during specific high-contact resident care activities .bathing/showering, providing hygiene, dressing, transferring, linen changes, toileting, device care, and wound care .signage will be posted on the door or wall outside of the resident room indicating the need for enhanced barrier precautions .carts with appropriate [Personal Protective Equipment] PPE will be placed outside of the resident's room .enhanced barrier precautions will be continued while the .indwelling device is still active or in use . Review of the Centers for Disease Control and Prevention (CDC) guidance titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) updated on 7/12/2022 reveals in part, .Enhanced Barrier Precautions All residents with any of the following .Wounds .During high-contact resident care activities . Dressing, Bathing .Transferring . Providing hygiene .Changing briefs or assisting with toileting .Gloves and gown prior to the high-contact care activity . 1a. Record review revealed Resident ID #84 was admitted to the facility in May of 2024 with a diagnosis including, but not limited to, MRSA. Record review of a care plan dated 4/3/2024 revealed the resident had an increased susceptibility for infections related to right foot wounds. Further review revealed enhanced barrier precautions are in place as ordered, to reduce the risk of a transmittable infection. Record review of lab results dated 5/6/2024 revealed the resident's right heel wound tested positive for MRSA. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor observation on 6/25/2024 at 12:11 PM of the resident's wound care revealed the following: Licensed Practical Nurse (LPN), Staff C, entered the resident's room with wound care supplies including, but not limited to, a multipack gauze, a calcium alginate sheet (a sterile absorbent wound dressing), 2 pairs of scissors, wound cleanser spray bottle, and wide medical tape. Staff C touched the wound wash spray bottle multiple times with dirty gloves while cleansing the wound as well as grabbing more gauze from the multi-package of gauze. Additionally, she placed the sheet of calcium alginate up to the wound bed to measure the area and cut the sheet to size. She then cut a piece of tape from the roll to adhere the wound dressing to the resident. Staff C performed hand hygiene and removed the roll of tape, multi-package of gauze, scissors, wound wash, and the remainder of the sheet of calcium alginate out of the resident's room and placed the items on the treatment cart in the hallway. Staff C began placing the items back into the treatment cart when she was stopped by the surveyor. During a surveyor interview immediately following the above observations with Staff C, she indicated that she was going to place the wound care items back into the treatment cart to be used for again for other residents. Additionally, she acknowledged that the resident was on enhanced barrier precautions in place related to MRSA in his/her wound. During a surveyor interview on 6/25/2024 at 1:04 PM with the Director of Nursing Services (DNS), she indicated that the wound care supplies should not have been removed from the resident's room and that those supplies should not be used for any other residents. 1b. Record review revealed Resident ID #28 was admitted to the facility in May of 2024 with a diagnosis including, but not limited to, a history of Extended Spectrum Beta Lactamase (ESBL, a MDRO) infection in his/her urine. Record review revealed an order dated 5/24/2024 for Enhanced Barrier Precautions. Surveyor observations on 6/24/2024 and 6/25/2024 failed to reveal evidence of a precaution bin or the appropriate signage posted outside of the resident's room indicating the need for Enhanced Barrier Precautions. During surveyor observations on the following dates and times staff were observed without the proper personal protective equipment (PPE). -6/25/2024 at 9:14 AM- Nursing Assistant, Staff N, in the resident's room, touching the bed and pillows, without wearing a gown -6/25/2024 at 9:56 AM- Staff N entered the resident's room and assisted the resident off of the bed pan without wearing a gown During a surveyor interview on 6/25/2024 at 10:11 AM with Staff N, she indicated that she helped the resident with toileting without wearing a gown because she was unaware that the resident had an order for enhanced barrier precautions. Additionally, she indicated that she was unaware that the resident had a history of ESBL. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview and observation of Resident ID #28's room on 6/25/2024 at 10:14 AM, with Certified Medication Technician (CMT), Staff M, she acknowledged there was no sign indicating the resident required Enhanced Barrier Precautions or that precaution bins were placed outside of the resident's room. During a surveyor interview on 6/25/2024 at 10:16 AM with Licensed Practical Nurse, Staff C, after reviewing the resident's medical record, she indicated that the resident was positive for ESBL in his/her urine and should have enhanced barrier precautions in place. During a surveyor interview on 6/25/2024 at 10:22 AM with the Infection Preventionist, she revealed the resident is positive for an ESBL infection. She further revealed that enhanced barrier precautions signage and a precaution cart with the necessary PPE should be outside of the resident's door for staff to utilize when providing care. During a surveyor interview on 6/25/2024 at 10:28 AM with the DNS, she acknowledged that Resident ID #28 should have enhanced barrier precautions in place as ordered. 1c. Record review revealed Resident ID #42 was admitted to the facility in January of 2023 with a diagnosis including, but not limited to, Alzheimer's disease. Additionally, the record revealed the resident has pressure ulcers (a localized injury to the skin or underlying tissue due to pressure) to the coccyx (tail bone) and left heel. During surveyor observations from 6/24/2024 through 6/26/2024 revealed the resident had a sign and a bin next to the entrance door to the room for enhanced barrier precautions. During a surveyor observation on 6/26/2024 at 10:42 AM, NA, Staff Q, entered the resident's room with supplies to provide personal care and indicated to the surveyor that she was ready to begin without wearing a gown. The surveyor then asked Staff Q to review the appropriate PPE needed for the resident. During a surveyor interview with Staff Q, immediately following the above observation, she acknowledged that she should wear a gown and gloves prior to providing personal care to the resident. During a surveyor interview on 6/26/2024 at 4:19 PM with the DNS, she revealed that she would expect staff to wear a gown and gloves to provide care for a resident who requires enhanced barrier precautions. 1d. Record review revealed Resident ID #163 was admitted to the facility in June of 2024 with a diagnosis including, but not limited to, gastrostomy tube (a tube inserted into the stomach to provide nutrition). During surveyor observations on 6/24, 6/25, and 6/26/2024, failed to reveal evidence of a precaution bin or the appropriate signage posted outside of the resident's room indicating the need for enhanced barrier precautions. During a surveyor interview on 6/26/2024 at 3:08 PM with LPN, Staff O, she indicated that she was unaware if the resident should have enhanced barrier precautions in place. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 6/26/2024 at 3:39 PM with the DNS, she indicated that the resident has a gastrostomy tube and would expect enhanced barrier precautions to be in place. 2. Review of the CDC document titled, Guidelines for Environmental Infection Control in Health-Care Facilities last updated July 2019, states in part, .Collecting, Transporting, and Sorting Contaminated Textiles and Fabrics .Handling contaminated laundry with a minimum of agitation can help prevent the generation of potentially contaminated lint aerosols in patient-care areas .Contaminated textiles and fabrics are placed into bags or other appropriate containment in this location; these bags are then securely tied or otherwise closed to prevent leakage . During a surveyor observation on 6/26/2024 at 8:45 AM, NA, Staff P, was observed changing Resident ID #92's bed linens and placing the soiled linens on the floor. During a surveyor interview with Staff P, immediately following the above observation, he indicated that he was unaware that he should not place dirty linens on the floor. During an interview with Licensed Practical Nurse, Staff C, immediately following the above observation and interview with Staff P, she acknowledged that soiled items, including bed linens, should not be placed on the floor. During a surveyor interview with the Regional Director of Clinical Services on 6/26/2024 at 3:35 PM, she indicated that she would expect staff members to place soiled linens in a bag and prevent soiled items from touching the floor.