STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415063	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayview Rehabilitation and Healthcare Center	860 North Quidnessett Road North Kingstown, RI 02852

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **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 appropriate treatment and services for 1 of 3 residents reviewed for constipation, Resident ID #2. Findings are as follows: Review of a community reported complaint received by the Rhode Island Department of Health on 8/30/2024 alleged that a resident had recently been admitted to the hospital from the facility with a diagnosis of, but not limited to, fecal impaction (a large, hard mass of stool that is stuck in the rectum that can cause serious illness or death). Record review revealed Resident ID #2 was admitted to the facility in July of 2024 with diagnoses including, but not limited to, dehydration, urinary tract infection, and Parkinson's disease. Review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 2 out of 15, indicating severely impaired cognition. Further review revealed the resident was incontinent of bowel and was dependent on staff for toileting. Review of a care plan dated 7/29/2024 revealed the resident has constipation related to decreased mobility, diminished appetite, and medication side effects with a goal to have a normal bowel movement at least every 3 days. Further review revealed the resident has Parkinson's Disease with interventions to monitor for constipation, implement the bowel regimen, monitor, and document effectiveness and to report ineffectiveness to a physician or designee. Record review of the bowel movement (BM) report revealed documentation that the resident did not have a bowel movement from 8/15/2024 until 8/22/2024, indicating that the resident did not have a bowel movement for 7 days. Record review revealed the following physician's orders for constipation dated 7/26/2024: - Milk of Magnesia (MOM) Suspension 400 milligrams(mg)/5 milliliters- administer 30 ml by mouth as needed - Dulcolax Suppository 10 mg- administer 1 suppository rectally as needed (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Fleet Enema 7-19 gm/118 ml- insert 1 application rectally as needed Record review of the August 2024 Medication Administration Record revealed MOM was administered on 8/19/2024, on the 5th day without a bowel movement, and on 8/20/2024, which were both documented as being ineffective. Further review revealed a Dulcolax Suppository was administered on 8/19/2024 and on 8/21/2024, which both were documented as being ineffective. Additional review revealed a Fleet Enema was administered on 8/22/2024, which was documented as ineffective. Record review of a progress note, dated 8/20/2024, authored by Advanced Practice Registered Nurse (APRN), Staff A, revealed .Nursing states patient having difficult BMs. [S/he] is on standing senna [a medication for occasional constipation], will add daily miralax . During a surveyor interview on 9/3/2024 at approximately 10:50 AM with Registered Nurse, Staff B, she indicated that the nurse on 2nd shift generates a BM report and creates a bowel list of residents who have not had a BM in 72 hours. She further indicated that the bowel protocol is to start with administering MOM, then a suppository if no BM and finally, an enema if still no BM. Additionally, she indicated that the physician should be notified if the resident has not had results from the bowel protocol and has not had a bowel movement for 3 days. Record review failed to reveal evidence that a provider was notified that the resident had not had a bowel movement for 7 days. During a surveyor interview on 9/3/2024 at 11:33 AM with Licensed Practical Nurse, Staff C, she indicated that a resident would be on a bowel list after 3 days without a bowel movement and the bowel protocol would be initiated. She further indicated that the physician should be notified if the resident has not had a bowel movement following the bowel protocol. Additionally, she acknowledged that the resident had not had a bowel movement for 7 days, from 8/15/2024 until 8/22/2024. The surveyor requested a copy of the facility's Bowel Protocol that Staff B and C were referring to during their interviews from the Director of Nursing Services (DNS) on 9/3/2024 at approximately 12:00 PM, and she indicated that the facility does not have a bowel protocol. During a surveyor interview on 9/3/2024 at 1:41 PM with Staff A, she indicated that she had assessed the resident on 8/20/2024 and was informed by the nursing staff that the resident was having difficulty with bowel movements, which she assumed meant that the resident was having small or hard BMs. She further indicated that she had not been made aware that the resident had not had any bowel movements for 6 days. She further stated that if she had been made aware that the resident had not had a bowel movement for 6 days, she would not have ordered Miralax daily but would have provided a different treatment or medication. During a surveyor interview on 9/3/2024 at 12:52 PM and again at 2:04 PM with the DNS, she indicated that she would expect as needed medications for constipation to be administered to the resident if they has not had a bowel movement in 3 days. She further indicated that she would expect the physician to be notified if the resident has not had a bowel movement in 4 to 5 days. Additionally, she could not provide evidence that a provider was notified that the resident did not have a bowel movement for 7 days.