

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415068	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/18/2024
NAME OF PROVIDER OR SUPPLIER  Warren Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  642 Metacom Avenue Warren, RI 02885	

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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>41729</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that residents are free of any significant medication errors for 1 of 3 residents reviewed, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Review of a facility reported allegation submitted to the Rhode Island Department of Health on 12/17/2024 revealed that a family member of the resident alleged that the resident did not receive his/her inhaler resulting in a hospitalization .</p> <p>Record review revealed the resident was admitted to the facility in September of 2023 and readmitted in December of 2024 with diagnoses including, but not limited to, pneumonia and dysphagia (difficulty swallowing).</p> <p>Record review revealed a physician's order dated November 19, 2024, for Ipratropium-Albuterol solution 0.5-2.5 milligram/3 milliliter inhaler four times a day at 7:30 AM, 11:30 AM, 4:30 PM and 9:30 PM (before meals and at bedtime ), for wheezing and shortness of breath.</p> <p>Record review of the Medication Administration Record failed to reveal evidence that the resident received his/her inhaler on the following dates and times:</p> <ul style="list-style-type: none"> <li>- 11/19/2024 at 4:30 PM and 9:30 PM</li> <li>- 11/20/2024 at 7:30 AM, 11:30 AM, 4:30 PM, and 9:30 PM</li> <li>- 11/21/2024 at 7:30 AM, 11:30 AM, and 4:30 PM</li> </ul> <p>Additional record review failed to reveal evidence that the provider was notified that the resident had not received his/her inhaler on the above-mentioned dates and times, as ordered.</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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview on 12/18/2024 at 12:06 PM with the Director of Nursing Services (DNS), she acknowledged that the resident did not receive his/her inhaler on the above-mentioned dates and times as ordered. The DNS acknowledged that when the order was entered in the resident's record by the provider on 11/19/2024, the nurse on duty did not verify the order therefore it was not sent to the pharmacy for delivery, as per the facility's process. She further acknowledged that because of this failure, the inhaler was not delivered to the facility until 11/21/2024 at 9:18 PM, which led to the resident not receiving the inhaler on the above-mentioned dates and times.</p> <p>During a surveyor interview on 12/18/2024 at 12:32 PM with a Nurse Practitioner, Staff A, she revealed that she was unaware that the inhaler was not administered on the above-mentioned dates and times until after 11/21/2024. She indicated that she would have expected the nurse to have sent the order to the pharmacy on 11/19/2024 and would expect the staff to have administered the inhaler, as ordered.</p>		