STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415078	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Respiratory and Rehabilitation Center of RI	10 Woodland Drive Coventry, RI 02816

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 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. 47939 Based on record review and staff interview, it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice relative to following a physician's order for 2 of 2 residents reviewed with an indwelling suprapubic catheter (a flexible tube that collects urine from the bladder and empties the urine into a drainage bag), Resident ID #'s 7 and 8. Findings are as follows: 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. Record review of a community reported complaint submitted to The Rhode Island Department of Health on 5/21/2024 alleges in part, that treatments were not completed as ordered on the day shift of 5/20/2024. 1. Record review revealed that Resident ID #7 was admitted to the facility in May of 2023 with diagnosis including, but not limited to, obstructive uropathy (excess urine collection in the kidneys) and benign prostatic hyperplasia (overgrowth of prostate tissue) with lower urinary tract symptoms. Record review revealed the following physician's orders: -5/28/2023- irrigate suprapubic catheter with 100 milliliters (ML) of normal saline every day and evening shift. -5/29/2023- Suprapubic care wash with soap and water and apply a dry protective dressing one time daily. Record review of the May 2024 Treatment Administration Record failed to reveal evidence that the above-mentioned suprapubic catheter treatments were administered as ordered on 5/20/2024 on the day shift. 2. Record review revealed the Resident ID #8 was admitted to the facility in June of 2021 with diagnosis including, but not limited to, Multiple sclerosis and neuromuscular dysfunction of the bladder (bladder dysfunction caused by an injury). (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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed the following physician's orders: -12/7/2023 irrigate suprapubic catheter with 60 ML's of normal saline three times a day. -6/8/2023 Zinc Oxide External Paste 40% wash buttocks then Apply topically two times daily for moisture associated skin damage -3/14/2024-Lidocaine External Gel 4% (local anesthetic) Apply to suprapubic catheter fistula opening topically every shift for irritation Place face cloth rolled up to lift abdominal fold and allow aeration to area, shift the catheter from right to left daily. Record review of the May 2024 Treatment Administration Record failed to reveal evidence that the above-mentioned treatments were administered as ordered on 5/20/2024 on the day shift. During a surveyor interview on 5/22/2024 at approximately 2:30 PM with the Director of Nursing Services she acknowledged that she worked as a floor nurse on 5/20/2024 and did not complete any of the above-mentioned treatments as she was too busy passing medications.

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F 0684 Level of Harm - 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** 47939 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, relative to promptly identifying and intervening during an acute change in a resident's condition, for 1 of 1 resident reviewed, Resident ID #1. Findings are as follows: Record review of a community reported complaint submitted to The Rhode Island Department of Health on 5/21/2024 alleges, Resident ID #1 had a new wound to his/her toe. Further review revealed the Physician's Assistant (PA) wanted to hospitalize the resident however, the facility administration refused to send the resident to the hospital. Review of a facility policy titled, Skin integrity and wound management review date 5/1/2024 states in part, .A comprehensive initial and ongoing nursing assessment of intrinsic and extrinsic factors that influence skin health, skin/wound impairment, and the ability of wound to heal will be performed. The plan of care for the patient will be reflective of assessment finding from the comprehensive patient assessment and wound evaluation. Staff will continually observe and monitor patients for changes and implement revision to the plan of care as needed . Record review revealed that Resident ID #1, was admitted to the facility in September of 2023 with diagnoses including, but not limited to, atrial fibrillation (an irregular often rapid heart rate that commonly causes poor blood flow) and peripheral vascular disease (circulatory disease in which narrowed blood vessels reduce blood flow to the limbs). Review of a change in condition form dated 5/18/2024 at 1:00 PM authored by Licensed Practical Nurse, (LPN) Staff A, revealed that on the 7:00 AM to 3:00 PM shift the resident was observed with new wounds to the his/her left great toe and left inner ankle. Additional review revealed that the resident complained of 7 of 10 pain to the toe and 4 of 10 pain to the left inner ankle. Further the resident was experiencing one plus pitting edema (indention when touched) to his/her lower extremities. Additional review of the change in condition form revealed a new order for a STAT (as soon as possible) Xray to the Left toes. Record review of the progress notes revealed the following: -5/19/2024 at 7:54 AM, Nursing notified the covering Nurse Practitioner that the x-ray to the left toes was negative for fracture. New order monitor for signs and symptoms of injury. -5/20/2024 at 6:25 AM, The resident was alert with intermittent confusion and continued with pitting edema to both lower extremities. -5/20/2024 at 2:23 PM, Resident was evaluated by the PA, new order for STAT venous and arterial ultrasound of the left foot to rule out vascular compromise. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review revealed a physician order dated 5/20/2024 for a STAT arterial and venous ultrasound to his/her right foot. Record review failed to reveal evidence that the above-mentioned ultrasound was completed. Record review revealed a physician's order dated 5/21/2024 for an additional STAT arterial and venous ultrasound for the resident's bilateral feet. Additional review of the progress notes revealed the following: -5/21/2024 at 1:46 PM, authored by the PA, Staff B, revealed the nursing staff was instructed if unable to obtain the ultrasound in a reasonable amount of time STAT the resident should be sent to the emergency room immediately. Additionally, nursing staff was instructed to apply compression stockings. Further review revealed patient has a history of congestive heart failure monitor patient progress should edema persist will order blood work. Awaiting ultrasound. Record review failed to reveal evidence of a physician's order to apply compression stockings. Further record review of the progress notes revealed the following: -5/21/2024 at 1:11 PM, PA notified that after four hours the STAT ultrasound had not been completed. -5/21/2024 at 8:10 PM, Authored by LPN, Staff C, revealed in part, Alert. Confused. Venous U/S [ultrasound] obtained to BLE [bilateral lower extremities] at approximately 5:00 PM .left toes remain purple in color. Right toes lighter purple/pink. BLE cool to touch from knee to feet. Faint PP [pedal pulses felt in the feet] bilat. [Both legs]. BPE [bilateral peripheral edema] noted .Right- lower extremity color is pale. Left-lower extremity color is pale. Right LE is cool to touch. Left lower LE is cool to touch . During a surveyor interview on 5/23/2024 at approximately 11:30 AM with Staff C, she acknowledged she completed the above-mentioned assessment for the resident. Additionally, she revealed she did not notify the provider of the resident exhibiting the above mentioned symptoms. Record review of a progress note dated 5/22/2024 at 6:56 AM authored by LPN, Staff E, revealed in part, . Still awaiting interpretation of venous ultrasound. Left toes remain purple in color. Right toes lighter purple/ pink. BLE cool to touch from knees to feet. Faint PP bilat . During a surveyor interview on 5/23/2024 at approximately 11:30 AM with LPN, Staff E, she acknowledged she completed the above-mentioned assessment for the resident on 5/21/2024. She further revealed she was aware that only a venous ultrasound was completed for the resident. She acknowledged she did not notify the provider of the resident experiencing the above-mentioned symptoms and that the arterial ultrasound has not been completed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a surveyor interview on 5/23/2024 at 11:48 AM with Physician Assistant, Staff B, he acknowledged the order he entered on 5/20/2024 for the ultrasound to the resident's right foot was erroneous and it should have been written for the residents left foot. Additionally, he revealed that he would have expected notification of the resident's change in condition as documented on 5/21/2024 on 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM. During a surveyor interview on 5/22/2024 at approximately 2:30 PM with the Director of Nursing Services (DNS), she revealed she would expect the resident would be assessed every shift for 72 hours, including a full set of vital signs after a change in condition is identified per policy. Additionally, acknowledged she was the nurse on duty on 5/20/2024 during the 7:00 AM and 3:00 PM and 3:00 PM to 11:00 PM shift and she did not complete a full assessment and did not obtain the residents vital signs. Furthermore she was unable to provide evidence why the ultrasound was not completed as ordered on 5/20/2024. Record review failed to reveal evidence of an assessment completed to include complete vital signs on the following dates and times: - 5/18/2024 3:00 PM to 11:00 PM - 5/19/2024 3:00 PM to 11:00 PM - 5/20/2024 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM Record review of a progress note dated 5/22/2024 at 8:00 AM, authored by RN, Staff A, revealed that the resident was sent to the emergency room related to worsening discoloration of both lower extremities with faint pedal pulses and both extremities cool to touch. Record review of a Radiology Results Report dated 5/22/2024 at 11:17 AM failed to reveal evidence that the arterial ultrasound to both feet was completed as ordered. During a surveyor interview on 5/23/2024 at 2:45 PM with the Medical Director, he revealed his expectation would be that the PA order would reflect the ultrasound to have been ordered for the correct foot on 5/20/2024. Additionally, he revealed he would have expected both the arterial and venous ultrasound to the resident bilateral feet to have been completed as ordered. Record review of the ED [Emergency Department] Documentation dated 5/22/2024 at 9:06 AM revealed that the resident had been transferred to the hospital by Emergency Medical Services (EMS) after worsening foot discoloration and swelling of his/her left and right feet. Both extremities were cool to touch, the left foot red/purple and right foot bluish purple in color. Wounds were noted to the right outer ankle and left inner ankle with three plus pitting edema. Review of the hospital documentation titled, History and Physical dated 5/22/2024 at 7:17 PM, revealed the following upon arrival to the hospital: -Blood Pressure (BP):129/94 (normal range 120/80) (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Pulse (P): 111 (normal range 60-100) -Respiratory Rate (RR): 20 (normal range 12-16) -White Blood Cells (WBC): 15.9 (normal range 4.0-11.0) Further record review revealed a plan including, but not limited to, suspect resident presentation likely due to peripheral embolization (state in which the blood vessel is obstructed by the lodgment of a material or mass), versus cellulitis, start heparin drip for suspected embolization,start antibiotics for treatment of acute cellulitis of left lower extremity with associated bacteremia(bacteria in the blood) related to tachycardia (elevated heart rate) and leukocytosis (higher than normal level of white blood cells) During a surveyor interview on 5/23/2024 at 12:29 PM with the DNS she was unable to provide evidence that the staff completed an assessment including a full set of vital signs every shift for 72 hours after a change in condition was identified on 5/18/2024. Additionally, she was unable to provide evidence that the provider was notified after the resident's change in condition as documented on 5/21/2024. Furthermore, she was unable to explain why the arterial ultrasound was not obtained as ordered prior to the residents hospitalization on [DATE].

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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 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. 47939 Based on record review and staff interview, it has been determined that the facility failed to ensure that a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 3 of 3 residents reviewed for pressure ulcers, Resident ID #'s 4, 5 and 6. Findings are as follows: Record review of a community reported complaint submitted to The Rhode Island Department of Health on 5/21/2024 alleges in part, treatments were not completed as ordered on the day shift 5/20/2024. 1. Record review revealed that Resident ID #4 was readmitted to the facility in April 2024 with a diagnosis including, but not limited to, unstageable pressure ulcer (characterized by full-thickness skin and muscle loss, with slough (moist dead tissue) or eschar (dry dead tissue) obstructing the wound bed). Record review revealed the following physician's orders dated 5/16/2024: -pressure injury sacrum (pelvic area) cleanse with wound cleanser, skin prep (skin protection wipe) around the wound, then pack the wound bed with collagen sheet and place a piece of calcium alginate (wound dressing), cover with a bordered foam dressing every day shift. -Stage 3 pressure injury (full-thickness loss of skin that extends to the hypodermis or subcutaneous tissue) of left gluteus cleanse with wound cleanser and pat dry, skin prep around the wound, then apply thera honey (wound ointment) to wound bed and cover with bordered gauze. Review of the May 2024 Treatment Administration Record failed to reveal evidence that the above mentioned treatments were completed on 5/20/2024, as ordered. 2. Record review revealed that Resident ID #5 was admitted to the facility in May 2024 with a diagnosis including, but not limited to, acute respiratory failure with hypoxia (a condition where you don't have enough oxygen in the tissues of the body). Record review revealed a physician's order dated 5/19/2024 to cleanse right buttock wound with wound cleanser, skin prep peri area and apply foam dressing every day shift. Review of the May 2024 Medication Administration Record failed to reveal evidence that the treatment was completed on 5/20/2024, as ordered. 3. Record review revealed that Resident ID #6 was admitted to the facility in April 2024 with a diagnosis including, but not limited to, unstageable pressure ulcer. Record review revealed a physician's order dated 5/9/2024 to apply phytoplex z-guard paste 57-17% (petrolatum-zinc oxide ointment) to bilateral buttocks two times daily for wound care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the May 2024 Treatment Administration Record failed to reveal evidence that the above mentioned treatment was completed on 5/20/2024 in the morning, as ordered. During a surveyor interview on 5/22/2024 at approximately 2:30 PM with the Director of Nursing Services she acknowledged that she worked as a floor nurse on 5/20/2024 and did not complete any of the above-mentioned treatments as she was too busy passing medications.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 47939 Based on record review and staff interview it has been determined that the facility failed to keep residents free from significant medication errors for 1 of 1 resident reviewed for insulin, Resident ID #2. Findings are as follows: Record review of a community reported complaint submitted to the Rhode Island Department of Health on 5/21/2024 alleges the Director of Nursing Services worked on 5/20/2024 from 7:00 AM through 11:00 PM and failed to administer insulin, as ordered. Record review revealed Resident ID #2 was admitted to the facility in February of 2024 with diagnoses including, but not limited to, diabetes and morbid obesity. Review of a physician's order dated 5/20/2024 revealed Semglee insulin, inject 16 units once per day for diabetes. Review of the May 2024 Medication Administration Record failed to reveal evidence the Semglee insulin was administered as ordered on 5/20/2024. Review of a physician's order dated 5/8/2024 revealed Lispro insulin inject subcutaneously (below the skin) per sliding scale before meals for diabetes. Review of the May 2024 Medication Administration Record failed to reveal evidence the resident's blood sugar was obtained and lispro insulin was administered as ordered per sliding scale on 5/14/2024 at 6:30 AM. Review of a physician's order dated 5/8/2024 revealed Admelog insulin, inject 34 units subcutaneously with meals for diabetes with instructions to hold the medication if the resident's blood sugar is less than 200. Review of the May 2024 Medication Administration Record revealed the following dates when the resident's blood sugar was less than 200 and the resident received 34 units of insulin when the medication should have been held per the physician's order. -5/4/2024 at 4:30 PM, blood sugar of 190 -5/6/2024 at 7:30 AM, blood sugar of 154 During a surveyor interview with the Director of Nursing Services on 5/22/2024 at approximately 2:30 PM, she could not provide evidence that the resident received his/her 16 unit of Semglee insulin and Lispro insulin 5/14/2024 at 6:30 AM. Additionally, she acknowledged that the resident's Admelog insulin should have been held on 5/4/2024 and 5/6/2024 per the physician's order.