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	08/22/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47939 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain a safe, clean, comfortable, and homelike environment relative to window air conditioners and exposed pipes in the hallway ceiling for 4 of 4 occupied facility units. Findings are as follows: Record review of a community reported complaint submitted to the Rhode Island Department of Health on 7/27/2024, alleges that the facility .has mold on the AC units [Air conditioner units] Water dropping from the ceiling, mold on the carpeting . During a surveyor observation on 8/21/2024 at 9:02 AM of the facility's window air conditioners and unit ceilings revealed the following: -1 North Unit, air conditioner in rooms 146, 147, 148, and 151 were observed with diffuse black matter on the air flaps and inside. Additionally, an air conditioner unit in the dining room across from 158 was observed with black matter on outside and inside of the air flaps. -2 South Unit, multiple air conditioner in rooms 229, 230, 232 and 233 with diffuse black matter on the air flaps and inside. -2 Vent Unit, hallway outside room [ROOM NUMBER] was observed with a heavy accumulation of black matter on the piping. -3 Memory Care Unit, room [ROOM NUMBER] air conditioner and air register outside room [ROOM NUMBER] were observed with a heavy accumulation of black matter inside and on the grating of the air register. During a surveyor interview on 8/21/2024 at 10:00 AM with the Maintenance Assistant, he acknowledged the above observations. He further revealed that the air registers and air conditioners should be cleaned or taken out of service. Additionally, he revealed that he was not aware of the black matter on the piping in the ceiling outside of 221 and that it would require an outside vendor to replace piping. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a surveyor interview on 8/21/2024 at approximately 12:30 PM with the Administrator, he was unable to provide evidence that the facility maintained a safe, clean, comfortable, and homelike environment.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47939 Based on record review staff and resident interview, it has been determined that the facility failed to ensure that the resident receives adequate supervision to prevent an elopement for 3 of 6 residents reviewed who were identified as an elopement risk, Resident ID #s 1, 2, and 4. Review of a community reported complaint received by the Rhode Island Department of Health on 8/14/2024 alleged that Resident ID #1 eloped from the facility over the weekend and was found at a local convenience store. Review of a facility policy titled, SLA111 Elopement of Resident last revised in May of 2024, states in part, . definitions elopement occurs when a resident who is cognitively, physically, mentally, emotionally .impaired and is no longer making decisions on their own behalf wanders away, walks away, runs away, escapes, or otherwise leaves the community or environment unsupervised, unnoticed sign in/out records will be maintained and utilized whenever a resident leaves the community grounds alone .Elopement drills will be conducted a minimum of twice per year and documented on elopement drill documentation form .if the behavior is due to an acute illness assist the family in providing private care or institute frequent checks to ensure resident safety .For resident who have a permanent decline in status notify the physician/provider and family in writing that the resident will be transferred to a secure dementia unit .until placement can be arranged, community staff and family will provide sufficient supervision to ensure resident safety. For residents identified as being at risk for elopement, an elopement prevention plan will be developed with resident and family participation .A communication will be provided to all care givers regarding the resident's risk for elopement and prevention measures . Review of a facility policy titled, OPS100 Accident/Incidents last revised 3/1/2024, states in part, POLICY center staff will report, review, and investigate all accidents/incidents which occurred .involving, a patient who is receiving services .The licensed nurse will Report accidents/incidents and assist with completion of timely investigation to determine root cause .implement appropriate interventions based on conclusions. Update the care plan and communicate with the patient and appropriate representative . 1. Record review revealed that Resident ID #1 was admitted to the facility in June of 2023 with diagnoses including, but not limited to, dementia, Bipolar (mood disorder), Neurocognitive disorder with Lewy bodies (a type of progressive dementia that leads to decline in thinking reasoning and independent functioning) and visual hallucinations. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating s/he has a moderate cognitive impairment. Record review of an Elopement Evaluation dated 6/7/2024 indicated that Resident ID #1 was able to self-propel in his/her wheelchair independently, has expressed a desire to leave and has a history of actual elopement or attempted elopement. Further review of this Elopement Evaluation failed to indicate whether the resident was identified as an elopement risk, or not considered an elopement risk, or if interventions should be implemented to ensure the resident's safety. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a care plan dated 7/26/2023 revealed Resident ID #1 exhibits verbal behaviors and behaviors not directed at others, has a history of picking at his/her skin and putting himself/herself on the floor. Interventions included, but were not limited to, evaluate the need and provide for psych and behavioral health consultation. Further review revealed a care plan dated 6/8/2023 indicating Resident ID #1 is at risk for complications related to psychotropic medication use with interventions including, but not limited to, completed behavior monitoring in the electronic medical record. Additional review of the resident's care plan revealed the document was revised on 9/7/2023 and indicated the resident is at risk for falls with interventions including to keep the resident within view of staff when out of bed to the wheelchair. Record review of the progress notes revealed the following: -7/17/2024 Resident history of dementia and intermittent behaviors s/he wishes to leave the facility and go to the restaurant however there is no safe conduit for him/her to do this. -7/23/2024 Resident states s/he was outside and decided to pick up cigarette remnants when leaning forward s/he fell forward out of his/her wheelchair. S/he complained of knee pain and was noted with abrasions to his/her hand and contusion (bruising) to his/her right knee. -8/7/2024 Chief complaint recurrent fall and alcohol abuse. Resident states that during his/her leave of absence s/he was drinking alcohol the resident's family member was upset with this. Being his/her healthcare proxy/power of attorney family states s/he is no longer allowed to leave unless accompanied by staff or going to a medical appointment. -8/8/2024 Chief complaint dementia resident is having increased behaviors requiring multiple redirections. Resident feels anxious. Resident continues to make a cognitive as well as physical decline related to his/her dementia and s/he often has memory lapses and does not recall information given to him/her. -8/10/24 a family member of another resident called the facility to make the facility aware the resident was noted to be at the local convenience store. Record review failed to reveal evidence of an intervention for Resident ID # 1 after s/he fell outside of the facility while unattended on 7/23/2024 attempting to pick up smoking remnants. Additionally, the facility failed to follow Resident ID#1's care plan relative to keeping him/her within view of staff while out of bed in his/her wheelchair. During a surveyor interview with the Director of Nursing Services on 8/15/2024 at 11:11 AM, he indicated that an Elopement Evaluation assessment dated [DATE] had identified that Resident ID #1 was at risk for elopement based on the results. Additionally, he acknowledged that the Elopement Evaluation utilized by the facility does not indicate whether the resident was identified as an elopement risk, or if interventions should be implemented to ensure the resident's safety. Additionally, he was unable to provide evidence of an intervention or update to the resident's plan of care after his/her fall on 7/23/2024 while outside of the facility unattended. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Additional record review failed to reveal evidence that interventions were implemented to remediate the resident's risk after s/he was found to be at risk for elopement on 6/7/2024. Record review revealed that on 8/10/2024, at an undetermined time, the facility was notified by a visitor that there was a resident at the convenience store approximately 0.2 miles from the facility. During a surveyor interview on 8/15/2024 at 11:36 AM, with Receptionist, she revealed the last time she saw the resident on 8/10/2024 was at approximately 10:00 AM in the lobby in his/her wheelchair. She indicated she was not aware of the resident's elopement risk status. 2. Record review revealed that Resident ID #4 was admitted to the facility in June of 2023 with a diagnosis including, but not limited to, dementia. Review of the MDS assessment dated [DATE] revealed a BIMS score of 12 out of 15, indicating s/he had a moderate cognitive impairment. Record review of an Elopement Evaluation dated 5/17/2024, which indicated that the Resident ID #4 was able to self-propel independently in his/her wheelchair, has a history of actual or attempted elopement, and has a history of wandering that places the resident at significant risk of getting to a potentially dangerous place. Further review of the Elopement Evaluation failed to indicate whether the resident was identified as an elopement risk, or not considered an elopement risk, or if interventions should be implemented to ensure the resident's safety. Record review of an Occupational therapy OT evaluation & plan of treatment, dated 7/2/2024, at 11:01 AM states in part, .At the time of evaluation, writer looked throughout the building and unable to locate [him/her]. Asked Registered Nurse (RN), Nursing Assistant and Unit Manger [sic] and no one knew where [s/he] was, as they assumed [s/he] was sitting outside in usual areas. At that time, receptionist came to let me know that another RN called the facility and stated [s/he] was at [a local convenience store] .this writer immediately went to the store .issues arose when approaching Rt. 3 there is no sidewalk access from [store parking lot] to woodland Drive, requiring client to drive into traffic on Rt. 3 to make a U-turn onto Woodland. Also, there are several patch jobs on the concrete that are showing significant wear and tear .[his/her] wheelchair did buckle/[NAME] with the changes in pitch. On woodland Drive, same issues no sidewalk. Did have changes in pitch with wear and tear of the pavement .it was determined [s/he] has no cell phone. This is a concern if the client has an issue of wheelchair getting stuck on uneven ground .also noted that there was no reflective tape or flag that increases [his/her] visibility for oncoming traffic .due path to [NAME] Farms .several areas of concern including uneven ground, with no way of calling for assistance if wheelchair became stuck or tips. Client needs to drive on the road due to no sidewalk access, including onto Rt. 3 with fast moving traffic. Recommendation .the client is supervised during traveling on Woodland Drive and Rt.3 to ensure [his/her] safety is maintained. Record review failed to reveal evidence of an update to Resident ID #4's plan of care related to the above-mentioned recommendation. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of an Elopement Evaluation assessment dated [DATE], which was conducted as a result of Resident ID #1's elopement on 8/10/2024 assessment indicated, that Resident ID #4 was able to self-propel independently in his/her wheelchair and has a history of wandering that places the resident at significant risk of getting to a potentially dangerous place. Further review of this Elopement Evaluation failed to indicate whether Resident ID #4 was identified as an elopement risk or if interventions should be implemented to ensure the resident's safety. Record review of a care plan dated 8/12/2024 revealed a focus care area indicating Resident ID #4 is at risk for elopement with a goal the resident will not attempt to leave the facility without an escort and interventions including, but not limited to, redirect resident if near exits or doorways. On 8/15/2024 at 11:36 AM during a surveyor interview being conducted over the telephone, the receptionist who was off duty, stated in part, [Resident ID #4] is down the street from the facility and should not be. She then tried to coax the resident into going back to the facility and Resident ID #4 would not. The surveyor immediately went to the Administrator's office and informed him that Resident ID #4 was observed by the receptionist down the street from the facility. During a surveyor interview and simultaneous observation on 8/16/2024 at 11:55 AM with Resident ID #4 s/he indicated that s/he goes outside when s/he wants. During a surveyor interview on 8/16/2024 at 11:59 AM with Registered Nurse, Staff A, she indicated that Resident ID #4 did not make her aware s/he was leaving the unit and going outside or off premises on 8/15/2024. Additionally, she indicated she was not aware of the resident's elopement risk identified on 5/17/2024 and 8/11/2024. Further, she was unaware that the resident had left the unit and was outside on 8/16/2024 at the time of the interview. During a surveyor observation on 8/16/2024 at 12:04 PM Resident ID #4 was observed outside the back door of the facility unattended in his/her motorized wheelchair. During a surveyor interview with the Director of Nursing Services immediately following the above-mentioned observation, he indicated Resident ID #4 requires supervision by staff when outside of the building. Additionally, he indicated he was unaware that the resident was outside unattended. 3. Record review revealed that Resident ID #2 was admitted to the facility in June of 2023 with diagnoses including, but not limited to, dementia with other behavioral disturbance and anxiety. Review of the MDS assessment dated [DATE] revealed a BIMS score of 7 out of 15, indicating s/he has a severe cognitive impairment. Record review of an Elopement Evaluation dated 8/11/2024 which was conducted as a result of Resident ID #1's elopement on 8/10/2024 assessment indicated, Resident ID #2 was able to self-propel independently in his/her wheelchair and has a history of wandering that places the resident at significant risk of getting to a potentially dangerous place. Further review of this Elopement Evaluation failed to indicate whether the resident was identified as an elopement risk or if interventions should be implemented to ensure the resident's safety. Review of a care plan dated 8/12/2024 revealed Resident ID #2 is at risk for wandering/elopement with an intervention including the resident will engage in unit therapeutic activities. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a surveyor interview on 8/15/2024 at 10:26 AM with Nursing Assistant, Staff B, she indicated she was assigned to Resident ID #2 and the resident is able to self-propel in his/her wheelchair. Additionally, she indicated she was unaware of the resident's risk for elopement or that there was an intervention in place. During a surveyor interview on 8/15/2024 at 11:01 AM with Licensed Practical Nurse, Staff C, she indicated she was not aware that Resident ID #2 was identified as an elopement risk. During a surveyor interview on 8/14/2024 at 3:02 PM and 8/16/2024 at 12:20 PM with the Director of Nursing Services, he acknowledged that the Elopement Evaluation assessments completed for resident ID #s 1, 2 and 4 indicated that they were an elopement risk and he was unable to provide evidence that the staff was educated on the possible risks identified. Additionally, he was unable to provide evidence that the facility implemented interventions to prevent the elopement of Resident ID #1 after his/her risk was identified on 6/7/2024. Further, he acknowledged Resident ID #s 1 and 4 were able to exit the facility and were located off facility premises going down the roadway toward a high traffic intersection. Lastly, he was unable to provide evidence that the facility implemented any interventions for Resident ID #4 after s/he was observed by staff off the premises on 8/15/2024. During a surveyor interview on 8/16/2024 at 3:35 PM with the Administrator, he was unable to provide evidence the facility preformed two elopement drills within 12 months, per facility policy. During a surveyor interview on 8/16/2024 at 3:54 PM with the Medical Director, he indicated it would his expectation that both Resident ID #1 and 4 would have been supervised by staff while outside of the building.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 47939 Based on record review and staff interview it has been determined that the facility failed to develop, implement, and maintain an effective training program, for existing staff, consistent with their expected roles, relative to education involving smoking per the facility assessment, for 5 of 5 staff reviewed, Staff A, D, E, F and G. Findings are as follows: According to the Facility Assessment, dated February 2024, which indicates the facility will provide care for resident who smoke. Record review failed to reveal evidence that the following staff completed smoking education: - Registered Nurse, Staff A, hired on 9/19/2023 - Registered Nurse, Staff D, hired on 7/5/2024 - Nursing Assistant, Staff E, hired on 9/18/2023 - Nursing Assistant, Staff F, hired on 2/3/2023 - Nursing Assistant, Staff G, hired on 3/14/2024 During a surveyor interview on 8/16/2024 at 3:02 PM, with the Director of Nursing Services, he was unable to provide evidence that training relative to smoking was completed for the above-mentioned staff. 21613

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 47939 Based on record review and staff interview, it has been determined that the facility failed to provide mandatory training to their staff, that outlines and informs staff of the elements and goals of the facility's QAPI (Quality Assurance and Performance Improvement) program, for 3 of 5 staff reviewed, Staff A, D, and E. Findings are as follows: Record review failed to reveal evidence that the following staff completed QAPI training or education: - Registered Nurse, Staff A, hired on 9/19/2023 - Registered Nurse, Staff D, hired on 7/5/2024 - Nursing Assistant, Staff E, hired on 9/18/2023 During a surveyor interview on 8/16/2024 at 3:02 PM, with the Director of Nursing Services, he was unable to provide evidence that the QAPI training was completed for the above-mentioned staff. 21613

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 47939 Based on record review and staff interview, it has been determined that the facility failed to provide all staff with behavioral health training, for 3 of 5 staff reviewed, Staff, A, D, and E. Findings are as follows: Record review failed to reveal evidence that the following staff completed the mandatory behavioral health training or education: - Registered Nurse, Staff A, hired on 9/19/2023 - Registered Nurse, Staff D, hired on 7/5/2024 - Nursing Assistant, Staff E, hired on 9/18/2023 During a surveyor interview on 8/16/2024 at 3:02 PM, with the Director of Nursing Services, he was unable to provide evidence that the behavioral health training was completed for the above-mentioned staff. 21613