

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415078	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/08/2024
NAME OF PROVIDER OR SUPPLIER Respiratory and Rehabilitation Center of RI		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0693</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>43987</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that residents that are fed through a feeding tube receive the appropriate treatment and services to prevent complications for 1 of 1 resident reviewed who receives nutrition and medications via Gastrostomy Tube (G-tube- is a feeding tube that provides supplemental feeding, hydration, or medicine directly to the stomach), Resident ID #21.</p> <p>Findings are as follows:</p> <p>Record review of a facility policy, revised on 6/1/2021, titled, Gastrostomy Tube (G-tube)/Percutaneous Endoscopic Gastrostomy (PEG) Tube Placement, states in part, .Document .Procedure .Site assessment . Patient's response, including any adverse effects .X-ray confirmation .</p> <p>Record review for the resident revealed s/he was admitted to the facility in April of 2023 with diagnoses including, but not limited to severe protein-calorie malnutrition resulting in gastrostomy tube placement.</p> <p>Record review reveals this resident is NPO (nothing by mouth).</p> <p>During the initial tour on 4/2/2024 at approximately 8:45 AM the resident was lying in bed with his/her eyes closed, non-verbal and s/he did not respond to the surveyor when she introduced herself.</p> <p>Review of a progress note, dated 4/2/2024 at 9:12 PM, revealed the resident's G-tube dislodged when a nurse attempted to flush it during medication administration.</p> <p>Further review of the notes revealed a physician's order on 4/2/2024 to insert a G-tube and obtain a STAT (immediately) KUB (x-ray to view the kidneys, ureters, and bladder) with Gastrografin (a contrast medium used for diagnostic examination of the gastrointestinal tract).</p> <p>Review of the KUB results, dated 4/3/2024 at 12:29 PM, failed to provide verification of the G-tube placement.</p> <p>Further record review failed to reveal evidence that, after the facility received the inclusive KUB results, they failed to contact the physician or follow-up with the contracted radiology vendor regarding the inclusive results on 4/3/2024.</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 0693</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor observation and simultaneous interview on 4/3/2024 at approximately 12:00 PM, with the resident's family member, s/he indicated that s/he was unaware that the resident's G-tube dislodged on 4/2/2024. Additionally, she acknowledged that the resident was grimacing in pain and indicated this is the only way of communicating that s/he is uncomfortable. S/he further revealed that s/he was upset as the resident was unable to receive any medication to alleviate his/her pain as the G-tube placement has yet to be confirmed.</p> <p>During a surveyor interview on 4/3/2024 at 1:56 PM with the Assistant Director of Nursing, she indicated that, although the G-tube was re-inserted, it cannot be used to administer medications, nutrition, or hydration until the proper placement of the G-tube is confirmed. She was unable to provide evidence of interventions that were implemented to address the resident's nutrition, hydration and medication needs while awaiting confirmation of the G-tube placement.</p> <p>Further record review of the progress notes dated 4/4/2024 revealed the following entries:</p> <p>-11:17 AM, Placement x-ray did not mention anything about tube placement so [radiology] was called and waiting on call back. Pt remains in bed with feed off and no meds given .</p> <p>-12:59 PM, Abdomen 1 view was interpreted by [radiologist, through a contracted vendor] again on 4/4 with findings that gastrostomy tube in the stomach .</p> <p>This indicates that the placement of the G-tube was verified, and the resident could resume receiving nutrition, hydration and medications that the resident had gone without for approximately 36 hours.</p> <p>During a surveyor interview on 4/4/2024 at 3:34 PM with Registered Nurse, Staff A, she acknowledged that the resident had not received any medication, nutrition, or hydration since 4/2/2024 at approximately 9:00 PM when his/her G-tube was dislodged. Furthermore, she was unable to explain why the resident's family member was not notified that his/her G-tube became dislodged on 4/2/2024.</p> <p>During a surveyor interview on 4/4/2024 at 4:32 PM with the Physician's Assistant, in the presence of the Interim Director of Nursing Services and the Lead Clinical Specialist, he indicated that he was unaware until the morning of 4/4/2024 that the resident's G-tube had dislodged on 4/2/2024. He stated that he would have expected the staff to follow clinical protocols and re-evaluate the resident. Additionally, he acknowledged that he did not prescribe any additional hydration to the resident who had not received any hydration since 4/4/2024 at approximately 9:00 PM.</p> <p>During a surveyor interview on 4/4/2024 at 4:47 PM with the Interim Director of Nursing Services in the presence of the Lead Clinical Specialist, she was unable to explain why there were no interventions implemented to address his/her hydration, nutrition or medications while the facility was awaiting g-tube placement confirmation.</p> <p>This failure by facility resulted in a non-verbal cognitively impaired resident with the inability to communicate hungry, thirst, pain or medical needs to go without nutrition, hydration, and medications for appropriately 36 hours.</p> <p>41720</p>		

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.</p> <p>37158</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure the medical care of each resident is supervised by a physician for 1 of 1 resident reviewed for abnormal laboratory results, Resident ID #94.</p> <p>Findings are as follows:</p> <p>Record review revealed the resident was admitted to the facility in May of 2021 with diagnoses including, but not limited to, hypothyroidism (a condition which the thyroid gland does not produce enough thyroid hormone), stroke and hypertensive heart disease.</p> <p>Further record review revealed the resident was admitted to hospice services (hospice care-focuses on the care, comfort, and quality of life of a person with a serious illness who is approaching the end of life) on 3/1/2024.</p> <p>Record review of a lab report dated 12/27/2023 revealed a TSH (thyroid stimulating hormone-test to see how well your thyroid is working) result of 0.23 IU (normal range 0.400-4.100 International Unit per Milliliter, indicating a low TSH level.</p> <p>Record review of a progress note dated 12/27/2023 and authored by the APRN (Advanced Practice Registered Nurse) Staff B, states in part, .Lab Review: Abnormal results .TSH 0.2. on levothyroxine [a medication to treat hypothyroidism] .Previously .150mcg .Assessment/Plan .Hypothyroidism: This is an acute new problem. The patient's condition is stable suprathereapeutic .Orders: levothyroxine 175mcg po daily, TSH in 6 weeks .</p> <p>Record review revealed a physician's order dated 12/27/2023 for Levothyroxine 175 mcg daily for 6 weeks.</p> <p>Record review of the February 2024 Medication Administration Record (MAR) revealed the 12/27/2023 Levothyroxine order was last signed off as administered on 2/6/2024. Additional review of the MAR revealed a new order for Levothyroxine 175 mcg with a start date of 2/22/2024, indicating the resident did not receive Levothyroxine from 2/7/2024 through 2/21/2024 which was 15 days.</p> <p>Record review of a nursing progress note dated 2/7/2024 states in part, Physician Notified .[name redacted] PA [physician assistant] .Labs Reviewed .TSH Physician Response .STAT TSH .</p> <p>Record review of a nursing progress note dated 2/7/2024 states in part, .Rec'd [received] results of TSH as 81.50 .</p> <p>Record review of the PA's progress note dated 2/9/2024 states in part, .Hypothyroidism .TSH came back at 81. Repeating TSH .</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47808</p> <p>Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to provide sufficient nursing staffing to ensure resident safety and attain the highest practicable, physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care relative to Activities of Daily Living (ADL) for 2 of 2 residents reviewed for ADL care needs, Resident ID #s 21 and 77.</p> <p>Findings are as follows:</p> <p>1. Record review revealed that Resident ID #21 was readmitted to the facility in April of 2023 with diagnoses including, but not limited to, dependence on respirator (a machine used to support or replace breathing) and stroke.</p> <p>Record review of a Minimum Data Set (MDS) assessment dated [DATE] revealed the resident requires the assistance of two staff members for bed mobility including turning from side to side, to and from a lying position, and transferring from bed to chair.</p> <p>Review of a care plan dated 5/2/2023 revealed the resident is dependent on staff for ADL care and requires total care for bathing, dressing, grooming and transfers via the use of a mechanical lift.</p> <p>During a surveyor observation on 4/5/2024 at 1:10 PM, of the resident while lying in his/her bed, revealed the foley catheter leaking as evidenced by the wet bed sheets. Nursing Assistant (NA), Staff C was observed to provide the resident with assistance and repositioned him/her without any help. In addition, she also changed the bed linens without the assistance of a second staff member while the resident was lying in bed.</p> <p>During a surveyor interview with Staff C immediately following the above observation, she acknowledged the resident requires the assistance of two staff members during care and revealed it is complicated, almost everyone is heavy.</p> <p>During a surveyor observation on 4/7/2024 at approximately 9:44 AM while in the resident's room during care, revealed NA, Staff D provided care to the resident without the assistance of another person.</p> <p>During a surveyor interview with Staff D immediately following the above observation, she revealed the resident requires the assistance of two staff members during care and indicated there is not enough help to provide care in a timely manner due to the high level of care and low staffing on the unit. Staff D further revealed there have been times when she has been assigned to provide care to 18-20 residents by herself.</p> <p>2. During surveyor observations on 4/5/2024 between the hours of 1:00-2:00 PM, of the staff's response to call lights revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-room [ROOM NUMBER]: At 1:00 PM the resident's call light was observed on. Staff responded at 1:38 PM.</p> <p>-room [ROOM NUMBER]: At 1:15 PM the resident's call light was observed on. Staff responded at 1:40 PM.</p> <p>-room [ROOM NUMBER]: At approximately 1:20 PM the resident's call light was on. Staff responded at 1:44 PM.</p> <p>During a surveyor interview on 4/3/2024 at 11:04 with Interim Director of Nursing (DON), she revealed staffing levels are determined by census and level of acuity and acknowledged that staffing remains a challenge. She revealed there have been times when she has had to work the unit when staffing has been low.</p> <p>During a surveyor interview with an anonymous staff on 4/5/2024 at 2:13 PM, she acknowledged the staffing remains low and is a challenge. S/he revealed that most of the residents on the vent unit require two staff members for care. She further revealed having only 2 NA's assigned to the unit pose challenges which includes answering call lights in a timely manner.</p> <p>During an interview on 4/4/2024 at approximately 6:30 PM with the Administrator while in the presence of the DON, they were unable to provide evidence that they have sufficient nursing staff to provide nursing related services to ensure residents safety and attain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and individual plans of care related to ADLs.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46338</p> <p>Based on surveyor observation, resident and staff interview, it has been determined that the facility failed to properly store, distribute, and serve food in accordance with professional standards for food service safety relative to 3 of 5 kitchenettes, 1 of 2 resident room refrigerators, and the cleanliness of 3 of 4 kitchenette ice machines.</p> <p>Findings are as follows:</p> <p>1. Surveyor observation of the North 3 unit kitchenette on [DATE] at 10:22 AM, revealed 1 two ounce (oz) package of non-individually wrapped Fig [NAME] cookies stored in the refrigerator, opened and not dated.</p> <p>During a surveyor interview on [DATE] at approximately 10:30 AM with Nursing Assistant (NA), Staff E she acknowledged the above observation.</p> <p>- Surveyor observation of the North 1 unit kitchenette on [DATE] at approximately 10:38 AM, revealed a box of ice cream bars that were opened and not dated.</p> <p>Additional observation revealed a 1.5 quart sized container of Breyers chocolate ice cream with freezer burn and was approximately ,d+[DATE] consumed that was not dated.</p> <p>During a surveyor interview on [DATE] at 10:45 AM with NA, Staff E, she indicated that she does not know when the containers of the items found in the refrigerator were opened and why they were not dated.</p> <p>- Surveyor observation of the first floor main dining room on [DATE] at approximately 12:00 PM revealed a small white refrigerator to the left corner of the kitchenette which contained an opened, an undated bag of waffles, and a wrapped bag of raw ground meat with an expiration date of [DATE].</p> <p>During an interview with the Assistant Food Service Director on [DATE] at 12:30 PM, he acknowledged that the raw ground meat was expired and should not be in the refrigerator.</p> <p>During an interview with the Food Service Director on [DATE] at 2:21 PM, she acknowledged the above findings.</p> <p>2. Record review revealed resident ID # 60 was readmitted to the facility in October of 2022, with diagnoses including, but not limited to, Macular Degeneration and legal blindness.</p> <p>Further record review revealed a physician order dated [DATE], which states in part, check refrigerator temperature in room twice daily.</p> <p>During a surveyor observation on [DATE] at 1:39 PM of the resident's room revealed a temperature log dated February 2024 on the exterior of the resident's refrigerator which revealed only one temperature was obtained and logged on [DATE].</p> <p>(continued on next page)</p>		

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