

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 03/21/2025
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47279</p> <p>Based on record review and staff interview, it has been determined that the facility failed to inform the resident's appointed representative, in advance, of the care to be furnished by the physician or other provider, of the risks and benefits of proposed care or treatment alternatives relative to the ordering of, and administration of, an antipsychotic medication for 1 of 2 residents reviewed for the use of Rexulti (an atypical antipsychotic medication), Resident ID #101.</p> <p>Findings are as follows:</p> <p>Review of a community reported complaint submitted to the Rhode Island Department of Health on 3/17/2025 alleges that the resident was started on Rexulti in January of 2025 and the resident was unable to provide consent. Additionally, a family member was never contacted about the addition of Rexulti nor advised of any risks or adverse reactions related to its use.</p> <p>Review of the facility policy titled, .Informed Consent last reviewed 2/1/2023 states in part, .Informed consent will be obtained from the patient or resident representative for all medical .high risk treatments .Evidence that informed consent has been obtained will be documented in the medical record .to ensure that the patient and/or representative has been apprised of the risks, benefits, and the alternatives related to .any high risk treatment .</p> <p>Review of the manufacturer's insert for Rexulti revised in July of 2015, revealed the following warning and precautions with Rexulti use for elderly individuals with dementia related psychosis:</p> <ul style="list-style-type: none"> - Increased risk of death - Increased risk of stroke <p>Record review revealed the resident was readmitted to the facility in November of 2024 with a diagnosis including, but not limited to, dementia with psychotic disturbance.</p> <p>Review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 3 out of 15, indicating severe cognitive impairment.</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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a document titled, RESIDENT REPRESENTATIVE DESIGNATION dated 10/14/2024 revealed that the resident appointed a family member to act on behalf of him/her in order to support his/her decision-making, which was signed by the resident, the resident's appointed family member, and a facility representative.</p> <p>Review of a progress note dated 1/15/2025, authored by the Physician Assistant, revealed that the resident has dementia and continues to have intermittent behaviors and baseline confusion. Additionally, an order for Rexulti 0.5 milligrams (mg) for 7 days was placed and was to be reevaluated for a continuance or increase in the medication. Further, it failed to reveal evidence that resident's representative was informed regarding the addition of Rexulti or the risks, benefits, and alternatives to the medication.</p> <p>Review of the January 2025 Medication Administration Record (MAR) revealed that the resident received Rexulti 0.5 mg daily from 1/16/2025 through 1/21/2025.</p> <p>Review of a progress note dated 1/21/2025 authored by the Physician Assistant, revealed that the resident was seen at the request of the nursing staff due to the continuance of behaviors. Additionally, his/her Rexulti 0.5 mg dose was discontinued, and s/he was to start Rexulti 1 mg daily. Further, it failed to reveal evidence that the resident's representative was informed regarding the dosage change to his/her Rexulti or the risks, benefits, and alternatives to the medication.</p> <p>Additional review of the January 2025 MAR revealed that the resident received Rexulti 1 mg daily from 1/22/2025 through 1/28/2025.</p> <p>Review of a progress note dated 1/29/2025 authored by the Physician Assistant, revealed that the resident was seen at the request of the nursing staff and for the reevaluation of his/her Rexulti use. Additionally, his/her Rexulti 1 mg dose was discontinued, and s/he was to start Rexulti 2 mg daily. Further, it failed to reveal evidence that resident's representative was informed regarding the dosage change to his/her Rexulti or the risks, benefits, and alternatives to the medication.</p> <p>Review of the January and February 2025 MAR revealed that the resident received Rexulti 2 mg daily on 1/30/2025 and 1/31/2025, and 2/1/2025 through 2/21/2025.</p> <p>Record review failed to reveal evidence that the resident's representative was informed, in advance, of the addition of Rexulti to the resident's medication regimen or subsequent dosage changes, or informed of the risks and benefits of Rexulti or treatment alternatives.</p> <p>During a surveyor interview on 3/21/2025 at 12:53 PM with the Director of Nursing Services, he revealed that he would have expected the nurse to discuss the addition of Rexulti to the resident's treatment plan or any changes made to the treatment plan with the resident's representative and document it in a progress note.</p>		

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<p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>47939</p> <p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that each resident was given a written accounting of his/her deposits, withdrawals, and balances at least quarterly for 5 of 7 residents reviewed, Resident ID #s 36, 41, 58, 69, and 252.</p> <p>Findings are as follows:</p> <p>1. Record review revealed that Resident ID #36 was admitted to the facility in February of 2017.</p> <p>Review of a facility provided document titled, Trial Balance dated 3/18/2025, revealed that Resident ID #36 has funds being held by the facility.</p> <p>Record review failed to reveal evidence of a quarterly statement for Resident ID #36.</p> <p>2. Record review revealed that Resident ID #41 was readmitted to the facility in December of 2023.</p> <p>Review of a facility provided document titled, Trial Balance dated 3/18/2025, revealed that Resident ID #41 has funds being held by the facility.</p> <p>Record review failed to reveal evidence of a quarterly statement for Resident ID #41.</p> <p>3. Record review revealed that Resident ID #58 was readmitted to the facility in February of 2024.</p> <p>Review of a facility provided document titled, Trial Balance dated 3/18/2025, revealed that Resident ID #58 has funds being held by the facility.</p> <p>Record review failed to reveal evidence of a quarterly statement for Resident ID #58.</p> <p>4. Record review revealed that Resident ID #69 was readmitted to the facility in January of 2025.</p> <p>Review of a facility provided document titled, Trial Balance dated 3/18/2025, revealed that Resident ID #69 has funds being held by the facility.</p> <p>Record review failed to reveal evidence of a quarterly statement for Resident ID #69.</p> <p>5. Record review revealed that Resident ID #252 was readmitted to the facility in February of 2025.</p> <p>Review of a facility provided document titled, Trial Balance dated 3/18/2025, revealed that Resident ID #252 has funds being held by the facility.</p> <p>Record review failed to reveal evidence of a quarterly statement for Resident ID #252.</p> <p>(continued on next page)</p>		

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<p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a surveyor interview on 3/20/2025 at 9:21 AM, with the Business Office Manager, she acknowledged that the above residents had not been provided a written accounting of his/her deposits, withdrawals, and balances at least quarterly per the regulation.</p> <p>During a surveyor interview on 3/20/2025 at approximately 10:30 AM, with the Administrator, she was unable to provide evidence that the facility provided quarterly statements for the above-mentioned residents for 2024.</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>47939</p> <p>50004</p> <p>Based on record review and staff interview, it has been determined that the facility failed to properly provide notice to residents and/or representatives informing them of when changes in coverage are made to items and services covered by Medicare and/or the state medical plan related to the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) of Non-coverage Form for 2 of 4 residents discharged from Medicare Part A Services that remained in the facility, Resident ID #s 64 and 402. Additionally, the facility failed to provide notice of Medicare Non-Coverage (NOMNC), in a timely manner for 2 of 4 residents reviewed who were discharged from a Medicare covered Part A stay with benefit days remaining, Resident ID #s 93 and 253.</p> <p>Findings are as follows:</p> <p>1. Review of the Center for Medicare and Medicaid Services (CMS) Form, CMS 100-55, titled Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage, states in part:</p> <p>Medicare requires SNFs [Skilled Nursing Facilities] to issue the SNFABN to Original Medicare, also called fee-for-service (FFS) beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is:</p> <ul style="list-style-type: none"> - not medically reasonable and necessary. - or considered custodial. <p>The SNFABN provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. SNFs must use the SNFABN when applicable for SNF Prospective Payment System services (Medicare Part A) .</p> <p>1a. Record review revealed that Resident ID #64's last covered day of Medicare Part A Services was on 12/5/2024. Further record review failed to reveal evidence that the resident and/or resident representative was issued the SNFABN form.</p> <p>1b. Record review revealed that Resident ID #402's last covered day of Medicare Part A Services was on 12/21/2024.</p> <p>Further record review failed to reveal evidence that the resident and/or resident representative was issued the SNFABN form.</p> <p>(continued on next page)</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Review of the Center for Medicare and Medicaid Services (CMS) Form, CMS-10123, titled Form Instructions for the Notice of Medicare Non-Coverage (NOMNC), states in part, .A Medicare provider or health plan (Medicare Advantage plans and cost plans, collectively referred to as plans) must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services. The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily .</p> <p>2a. Record review revealed that Resident ID #93's last covered day of Medicare Part A Services was on 2/12/2025.</p> <p>Further record review failed to reveal evidence that the resident and/or resident representative was issued the NOMNC form.</p> <p>2b. Record review revealed that Resident ID #253's last covered day of Medicare Part A Services was on 1/13/2025.</p> <p>Further record review failed to reveal evidence that the resident and/or resident representative was issued the NOMNC form.</p> <p>During a surveyor interview on 3/20/2025 at 12:30 PM, with the Business Office Manager, she revealed that Resident ID #s 64 and 402 should have been issued the SNFABN form and was unable to provide evidence that the SNFABN form was completed. Additionally, she acknowledged that Resident ID #s 93 and 253 should have been provided with a NOMNC and was unable to provide evidence that the resident and/or resident representative was issued the NOMNC form.</p> <p>During a surveyor interview on 3/20/2025 at 12:59 PM, with the Administrator, she was unable to provide evidence that the facility provided the SNFABN notice for Resident ID #s 64 and 402 and was unable to provide evidence that the resident and/or resident representative was issued the NOMNC form for Resident ID #s 93 and 253.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47279</p> <p>Based on surveyor observation, record review, resident, and staff interview, it has been determined that the facility failed to keep a resident free from neglect for 1 of 1 resident reviewed for activities of daily living (ADLs), Resident ID #452.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled, Abuse Prohibition last reviewed on 2/23/2021 states, in part, .Neglect is defined as the failure of the Center, its employees, or service providers to provide goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress .</p> <p>Review of a facility policy titled, .Activities of Daily Living (ADLs) last revised 5/1/2023 states in part, . Activities of daily living (ADLs) include: Hygiene - bathing, dressing, grooming, and oral care; Mobility - transfer and ambulation, including walking; Elimination - toileting .A patient who is unable to carry out ADLs will receive the necessary level of ADL assistance to maintain good nutrition, grooming, and personal and oral hygiene .Documentation of ADL care is recorded in the medical record and is reflective of the care provided by the nursing staff .ADL care will be documented in real time, as close to the time that care was provided .ADL care is documented every shift by the nursing assistant .</p> <p>Record review revealed Resident ID #452 was admitted to the facility on [DATE] with diagnoses including, but not limited to, anxiety, recurrent depressive disorders, and urinary tract infection.</p> <p>Review of a document completed on 3/13/2025, the resident's day of admission, revealed that s/he is Alert oriented x 3 indicating that s/he is alert and orientated to person, place, and time.</p> <p>Review of an occupational therapy document dated 3/14/2025 revealed that s/he requires moderate assistance for grooming and max assistance to bathe/dress his/her upper body. Additionally, s/he requires total dependence to bathe/dress his/her lower body, toileting, and transfers.</p> <p>Review of his/her care plan revealed a focus area dated 3/14/2025 indicating that the resident is at risk for decreased ability to perform ADLs including, but not limited to, grooming, personal hygiene, dressing, and toileting.</p> <p>a. Record review revealed that the resident was being treated with anti-fungal powder to his/her peri area twice daily and as needed. The order was changed to three times daily on 3/17/2025. Further, it revealed that s/he is incontinent of urine.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a continuous surveyor observation and simultaneous interview on 3/18/2025 at approximately 11:20 AM, with the resident, s/he was observed in his/her room seated in a wheelchair adjacent to his/her bed and was wearing a hospital gown. S/he revealed that the staff take a long time to respond to the call light and that the nursing assistants do not provide ADL care for him/her, only the therapists do. S/he further revealed that a nursing assistant (NA) had come into his/her room earlier only to make the bed, but s/he had not been provided assistance with washing or dressing. At the surveyor's request, s/he triggered the call light response system at 11:22 AM. Approximately 2 minutes later, an unidentified staff member answered the call light via the telecom system. The resident informed this staff member that s/he needed his/her brief changed. The staff member indicated that they would inform therapy so s/he could be transferred back to bed then s/he could be changed. At 11:55 AM, approximately 30 minutes later, the resident indicated to the surveyor that s/he needed to be changed as s/he could not wait any longer because s/he was being treated for a rash in his/her peri area and was uncomfortable, and again, triggered the call light at the surveyor's request. At 11:56 AM, a respiratory therapist entered his/her room and indicated to the resident that she would inform the resident's NA that s/he needed to be changed. At 11:58 AM, 2 NAs, Staff A and Staff B, entered his/her room and indicated to the resident, with the surveyor present, that they could not change him/her until therapy transferred him/her back to bed first.</p> <p>During a surveyor interview immediately following the above observation with Staff A and Staff B, they revealed that they are not able to transfer the resident because s/he is still being evaluated by therapy. They further revealed that neither of them had answered the resident's call light via the telecom system at 11:22 AM and indicated that NAs do not respond to the call light telecom system, are unable to shut off the call light via the telecom system, and staff must physically turn off the call light in the resident's room. Additionally, Staff B informed the surveyor that s/he had physically responded to the resident's call light only a few minutes earlier, however the surveyor had continuously observed the resident and did not observe Staff B to have physically responded to his/her call light minutes earlier as Staff B indicated.</p> <p>During a subsequent surveyor observation on 3/18/2025 at 12:03 PM, Physical Therapist, Staff C, was observed to enter the resident's room and transfer the resident back to bed from his/her wheelchair. Additionally, at approximately 12:10 PM, Staff A and Staff B entered the resident's room to provide incontinence care for the resident, approximately 48 minutes after the resident initially triggered his/her call light and informed staff that s/he needed his/her brief changed.</p> <p>During a surveyor interview on 3/18/2025 at approximately 12:10 PM with Staff C, following the above observation, he revealed that there are no restrictions for the NAs to transfer the resident, and s/he does not require a therapist's assistance for transfers.</p> <p>During a surveyor interview on 3/18/2025 at 12:18 PM with Registered Nurse, Staff D, she revealed that she is the nurse assigned to care for the resident. She further revealed that the resident has been working with therapy and the resident requires max assistance for transfers and would expect the nursing assistants to transfer the resident from his/her wheelchair back to his/her bed to provide incontinence care. Additionally, she revealed that the resident has a painful fungal rash to his/her peri area and the provider recently changed the treatment from twice daily to three times daily and as needed. Furthermore, she indicated that the NAs primarily answer the call light telecom system located at the desk, and that they are able to turn off a call light via the telecom system.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. During a surveyor observation and simultaneous interview on 3/18/2025 at approximately 11:20 AM with the resident, s/he was observed in his/her room seated in a wheelchair adjacent to his/her bed and was wearing a hospital gown. S/he revealed that an NA had come into his/her room earlier only to make the bed, but s/he had not been provided assistance with washing or dressing and would like to be washed and dressed. S/he further revealed that a therapist had come in earlier that morning and provided incontinence care and conducted a brief therapy session, but did not assist him/her with washing or dressing.</p> <p>During a surveyor interview on 3/18/2025 at approximately 12:00 PM with Staff A and Staff B, they revealed that neither of them were assigned to care for the resident on 3/18/2025 during the 7:00 AM - 3:00 PM shift, and indicated that the resident was on NA, Staff E's, assignment.</p> <p>During a surveyor interview on 3/18/2025 at 12:18 PM, with the resident's nurse, Staff D, she revealed that she would have expected that the resident's ADL care to have already been completed by this time.</p> <p>During a surveyor interview on 3/18/2025 at 12:26 PM, with Staff E, he revealed that he was unaware that he was assigned to provide care for the resident on 3/18/2025 on the 7:00 AM - 3:00 PM shift. Additionally, after reviewing the NA assignment sheet with him, he acknowledged that he was the NA responsible for providing care for the resident that day.</p> <p>During subsequent observations and simultaneous interviews on 3/18/2025 at 2:11 PM and 3:04 PM with the resident, s/he was observed still in his/her bed in a hospital gown. S/he revealed that s/he was not provided any assistance with personal hygiene, assistance with being washed or dressed and was unsure of who his/her NA was during the 7:00 AM - 3:00 PM shift.</p> <p>During a surveyor interview on 3/18/2025 at 3:07 PM with Staff E, he revealed that he did not provide any assistance with ADLs for the resident on 3/18/2025 on the 7:00 AM to 3:00 PM shift because it was completed by a therapist.</p> <p>During a surveyor interview on 3/18/2025 at 3:10 PM with Occupational Therapist, Staff F, he revealed that on 3/18/2025 during the 7:00 AM to 3:00 PM shift, he set the resident up for mouth care and provided incontinence care, but did not assist him/her with washing, grooming, or dressing.</p> <p>Record review failed to reveal evidence that the resident received assistance with ADL care, personal hygiene or dressing on 3/18/2025 during the 7:00 AM - 3:00 PM shift even after the surveyor's concern for the resident's care was brought to the facility's attention.</p> <p>During a surveyor interview on 3/19/2025 at approximately 11:00 AM with the Director of Nursing Services, he revealed that he would have expected the NAs to have transferred the resident back to bed to provide incontinence care. Additionally, he revealed that all residents should receive assistance with ADL care as needed and it should be documented accordingly.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50004</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that the assessment accurately reflected the resident's status for 1 of 1 resident reviewed with a diagnosis of schizophrenia, Resident ID #66.</p> <p>Findings are as follows:</p> <p>Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual last revised in October of 2024 states in part, Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period .</p> <p>Record review revealed Resident ID #66 was admitted to the facility in February of 2024 with a diagnosis including, but not limited to, bipolar disorder.</p> <p>Record review revealed a Preadmission Screening and Resident Review (PASRR) dated in January of 2024, with a diagnosis of bipolar disorder. Further review of the document revealed that schizophrenia was not a documented diagnosis.</p> <p>Review of an Admission MDS assessment dated [DATE], Section I, titled, Active Diagnoses in the Last 7 Days revealed the resident was not coded with an active diagnosis of schizophrenia.</p> <p>Review of the following MDS Assessments, Section I, titled, Active Diagnoses in the Last 7 Days revealed the resident was coded with an active diagnosis of schizophrenia:</p> <p>-5/9/2024</p> <p>-7/11/2024</p> <p>-10/9/2024</p> <p>-1/9/2025</p> <p>During a surveyor interview on 3/20/2025 at 3:08 PM, with the MDS Coordinator, she revealed that the schizophrenia diagnosis was added to the resident's medical record in May of 2024, prior to her starting in the MDS Coordinator position and was unaware of where it came from. Additionally, she acknowledged that she did code it on the 1/9/2025 assessment without any supporting documentation.</p> <p>During a surveyor interview on 3/21/2025 at 11:04 AM, with the Physician Assistant in the presence of the Administrator, he revealed that he obtained the schizophrenia diagnosis from facility documentation or a consult but was unable to provide evidence of documentation that supports a diagnosis of schizophrenia for Resident ID #66.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Respiratory and Rehabilitation Center of RI		STREET ADDRESS, CITY, STATE, ZIP CODE 10 Woodland Drive Coventry, RI 02816	
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 3/21/2025 at 11:15 AM, with the Administrator, she acknowledged that the above MDS assessments included a diagnosis of schizophrenia without any supporting documentation.		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>48928</p> <p>Based on record review and staff interview, it has been determined that the facility failed to implement and revise a care plan after each assessment for 1 of 2 residents reviewed for falls, Resident ID #21.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled Falls Management last revised on 3/15/2024 states in part, .Implement and document patient centered interventions according to individual risk factors in the patients care plan .</p> <p>Record review revealed Resident ID #21 was readmitted to the facility in April of 2024, with diagnoses including, but not limited to, dementia, difficulty walking, and unsteadiness on feet.</p> <p>Record review revealed the following:</p> <p>-1/5/2025 - The resident sustained an unwitnessed fall, s/he was found lying on his/her back on the floor in his/her room.</p> <p>Review of a care plan with a focused area for risk for injury related to falls, revealed an intervention initiated on 1/5/2025, for a bedside mat on floor to right side of the bed at all times while resident is in bed.</p> <p>-2/11/2025 - The resident sustained an unwitnessed fall while attempting to get out of bed unassisted, fell hitting the left side of his/her face resulting in swelling to the left eye and bruising to his/her face.</p> <p>Review of the care plan failed to reveal evidence of a revised intervention after the residents fall on 2/11/2025.</p> <p>-2/12/2025 - The resident was found sitting on the mat next to his/her bed with his/her head resting on the mattress of the bed.</p> <p>Review of a care plan with a focused area for risk of falls revealed an intervention initiated on 2/13/2025 to implement frequent checks once s/he is in his/her bed.</p> <p>-3/20/2025- The resident sustained an additional unwitnessed fall, s/he reported s/he was attempting to get out of bed and fell .</p> <p>During a surveyor interview on 3/21/2025 at 9:24 AM, with Registered Nurse, Staff G, she revealed that she was unaware that the care plan was not revised with a new intervention for the addition fall on 2/11/2025. Additionally, she was unable to provide evidence that the fall risk intervention added on 2/13/2025, to implement frequent checks when the resident is in his/her bed, had been implemented.</p> <p>(continued on next page)</p>		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 3/21/2025 at 10:25 AM with the Director of Nursing Services, he acknowledged that the residents care plan failed to reveal evidence of a revised intervention after his/her subsequent fall on 2/11/2025. Additionally, he was unable to provide evidence that the fall risk intervention added on 2/13/2025, to implement frequent checks when the resident is in his/her bed, had been implemented.		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>48928</p> <p>Based on record review and staff interview, it has been determined that the facility failed to meet professional standards of quality relative to failure to follow a physician's order for 1 of 1 resident reviewed for daily weights, Resident ID #23.</p> <p>Findings are as follows:</p> <p>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 .</p> <p>Record review revealed the resident was admitted to the facility in February of 2022 with diagnoses including, but not limited to, chronic obstructive pulmonary disease (a lung condition caused by damage to the lungs) and type 2 diabetes mellitus with diabetic chronic kidney disease (when the kidneys are damaged over time due to high blood sugar).</p> <p>Record review revealed an active physician's order with a start date of 7/31/2024, that states daily weights in the morning for monitoring.</p> <p>Record review failed to reveal evidence that daily weights were obtained between 7/31/2024 through 3/21/2025.</p> <p>During a surveyor interview on 3/20/2025 at 8:51 AM, with Registered Nurse, Staff G, she indicated that she was unaware that Resident ID #23 had an active physician's order for daily weights. She further revealed that daily weights had not been obtained between 7/31/2024 through 3/21/2025.</p> <p>During a surveyor interview on 3/20/2025 at approximately 10:30 AM with the Dietitian, she revealed that she was unaware of the active physician order for daily weights that was ordered on 7/31/2024.</p> <p>During a surveyor interview on 3/21/2025 at 10:47 AM with the Director of Nursing Services, he acknowledged that the resident had an active physician order for daily weights ordered on 7/31/2025, and he revealed it would be his expectation for the weights to have been obtained as ordered.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>50004</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that residents who require dialysis (a treatment that removes excess fluid, waste, and toxins from the blood when the kidneys are no longer functioning properly) receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 1 resident reviewed for communication with the dialysis center, Resident ID #64.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled, Dialysis: Hemodialysis [HD] . states in part, .Shared Communication Between the Center and the Certified ESRD [End-stage renal disease] Facility .Communication topics . Declines in functional status, falls, the identification of symptoms such as anxiety, depression, confusion . Changes and/or decline in conditions unrelated to HD .</p> <p>Record review revealed that Resident ID #64 was readmitted to the facility in February of 2025, with a diagnosis including, but not limited to, ESRD.</p> <p>Record review revealed that the resident attends dialysis three times a week on Monday, Wednesday, and Friday.</p> <p>Record review of a provider note dated 3/11/2025, authored by the Physician Assistant states in part, .GI bleed [gastrointestinal bleed] .Nurse staff reports bright red blood per rectum .Patient adamantly declines emergency room evaluation. Order placed for blood work .Patient in the past been seen in emergency room for GI bleed requiring transfusion .</p> <p>Review of the dialysis communication binder, communication sheets, and record failed to reveal evidence that the facility notified the dialysis center of the resident's GI bleed.</p> <p>Record review of a progress note dated 3/13/2025, authored by the Physician Assistant revealed that the resident had a witnessed fall on 3/12/2025 with two nursing assistants during a transfer to his/her wheelchair. Additionally, the provider ordered that all transfers require a Hoyer lift (a mechanical lift, a device designed to assist caregivers in safely transferring patients) and instructed staff to contact dialysis and provide an update as to his/her current medical standing.</p> <p>Review of the dialysis communication binder, communication sheets, and record failed to reveal evidence that the facility notified the dialysis center of the resident's fall and change in transfer status.</p> <p>During a surveyor interview on 3/20/2025 at 8:59 AM, with Registered Nurse, Staff H, she revealed that the resident sustained a fall on 3/12/2025. Additionally, she revealed that she was unaware that the facility policy states to notify the dialysis center with changes such as a change in condition or falls and stated, any information that the facility would send would be included in the dialysis binder.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview on 3/20/2025 at 11:37 AM, with the Director of Nursing Services, he acknowledged that the resident's communication binder, communication sheets, and record failed to reveal evidence that the facility notified the dialysis center of the resident's GI bleed, fall, and change in transfer status. Additionally, he revealed that he was unaware that the facility had to notify the dialysis center of a fall, although the facility policy states to do so.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>47939</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure the irregularities identified by the Consultant Pharmacist during the monthly pharmacist Medication Regimen Review (MRR) were acted upon for 1 of 2 residents reviewed for admission medication reconciliation, Resident ID #93.</p> <p>Findings are as follows:</p> <p>Record review revealed that the resident was admitted to the facility in January of 2025 with diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD, a lung condition caused by damage to the lungs.) and bacterial pneumonia.</p> <p>Record review revealed the following physician's orders:</p> <p>-1/7/2025 prednisone (a medication prescribed to decrease inflammation) 40 milligrams (mg), give one tablet once daily for COPD</p> <p>-1/7/2025 doxycycline (a medication prescribed to treat infection), 100 mg, give one tablet two times daily for pneumonia</p> <p>Record review of a new admission MRR form dated 1/8/2025, authored by the pharmacist, revealed a recommendation to the facility to clarify a stop date for the doxycycline. Additionally, the review indicates to clarify a stop date or taper order (a gradual reduction of a medication over time until discontinued) for the prednisone order.</p> <p>Record review of a MRR dated 1/22/2025 revealed a repeat recommendation to clarify the doxycycline order with a stop date.</p> <p>Record review of a MRR dated 2/27/2025 revealed a repeat recommendation to clarify a stop date or taper order for the prednisone.</p> <p>Review of the January, February, and March 2025 Medication Administration Records (MAR) revealed that the resident was administered the doxycycline on the following dates:</p> <p>-1/7/2025, through 3/19/2025, twice daily for a total of 141 doses.</p> <p>Further review of the January, February, and March 2025 MAR revealed that the resident was administered the prednisone on the following dates:</p> <p>-1/8/2025, through 3/19/2025, once daily for a total of 71 doses.</p> <p>During a surveyor interview on 3/21/2025 at 10:15 AM with the Director of Nursing Services, he was unable to provide evidence that the residents MRR recommendations were acted upon.</p> <p>(continued on next page)</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a surveyor interview on 3/21/2025 at 4:16 PM via the telephone with the resident's Physician he indicated it would be his expectation for the prednisone to have been tapered and the doxycycline to have been stopped per the pharmacist's recommendations.</p> <p>Cross Reference F 757 and F 881.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>47939</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that the resident's drug regimen is free from unnecessary drugs for 1 of 2 residents reviewed for admission medication reconciliation, Resident ID #93.</p> <p>Findings are as follows:</p> <p>Record review revealed that the resident was admitted to the facility in January of 2025 with diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD, a lung condition caused by damage to the lungs) and bacterial pneumonia.</p> <p>Record review of a Continuity of Care Discharge/Transfer of Patient Form (COC) dated 1/1/2025 revealed an attached communication form titled Discharge summary with the following physician's orders:</p> <p>-prednisone 40 milligrams (mg), give one tablet once daily for 4 days, which indicates the medication would be discontinued on 1/5/2025.</p> <p>-doxycycline 100 mg, give one tablet two times daily for 2 days which indicates the medication would be discontinued on 1/3/2025.</p> <p>Record review revealed the following physician's orders:</p> <p>-1/7/2025 prednisone 40 mg, give one tablet once daily for COPD</p> <p>-1/7/2025 doxycycline 100 mg, give one tablet two times daily for pneumonia</p> <p>Review of the January, February, and March 2025 Medication Administration Records (MAR) revealed that the resident was administered the doxycycline on the following dates:</p> <p>-1/7/2025 through 3/19/2025, twice daily for a total of 141 doses.</p> <p>Further review of the January, February and March 2025 MAR revealed that the resident was administered the prednisone on the following dates:</p> <p>-1/8/2025 through 3/19/2025, once daily for a total of 71 doses.</p> <p>Record review of a new admission medication record review (MRR) form dated 1/8/2025, authored by the Pharmacist, revealed a recommendation to the facility to clarify a stop date for the doxycycline and a stop date or tapering order (a gradual reduction of a medication over time until discontinued) for the prednisone.</p> <p>Record review of an MRR dated 1/22/2025 revealed a repeat recommendation to clarify the doxycycline order with a stop date.</p> <p>(continued on next page)</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of an MRR dated 2/27/2025 revealed a repeat recommendation to clarify a stop date or taper for the prednisone.</p> <p>During a surveyor interview on 3/21/2025 at 10:15 AM with the Director of Nursing Services, he acknowledged that the COC from the resident's admission indicated the doxycycline and prednisone should have been discontinued prior to the resident's admission to the facility. He further indicated it would be his expectation that the complete COC would have been reviewed during his/her admission medication reconciliation. Additionally, he was unable to provide evidence that the residents drug regimen was kept free from unnecessary drugs.</p> <p>During a surveyor interview on 3/21/2025 at 11:05 AM with the Physician Assistant he indicated he was not aware of the stop dates for both medications list on the admission COC.</p> <p>During a surveyor interview on 3/21/2025 at 4:16 PM via the telephone with the resident's Physician he indicated he would have expected the facility to follow the order to discontinue the medications listed on the COC. Additionally, he indicated that the doxycycline should have only continued for a few days and that the prednisone should have been tapered.</p> <p>Cross Reference F 756 and F 881.</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>47939</p> <p>46539</p> <p>Based on record review and staff interview, it has been determined that the facility failed to document all required components of the facility-wide assessment. Additionally, the facility failed to review and update the assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment.</p> <p>Findings are as follows:</p> <p>Review of an undated and unsigned facility document titled, Facility Assessment, for the year of 2025, failed to reveal evidence of the active involvement of the following participants in the process:</p> <p>1. Nursing home leadership and management, including but not limited to, a member of the governing body, the Medical Director, an Administrator, and the Director of Nursing Services (DNS).</p> <p>Record review of the Assessment Contributors section, revealed of the 13 management staff listed including the Administrator, the DNS, and the Medical Director, 11 of them were no longer employed at the facility.</p> <p>2. The facility must also solicit and consider input received from residents, resident representatives, and family members.</p> <p>Record review failed to reveal evidence that the facility solicited and considered input received from residents, resident representatives, and family members.</p> <p>During a surveyor interview on 3/20/2025 at 3:37 PM, with the Administrator, she was unable to provide evidence that the facility included all required components of the facility-wide assessment and completed any changes that would require a substantial modification to any part of this assessment as mentioned above.</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>47939</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to implement and maintain an effective, comprehensive, data-driven, Quality Assurance and Performance Improvement (QAPI) program that focuses on indicators of the outcomes of care and quality of life. Additionally, the facility failed to make a good faith attempt to correct the identified concern of antibiotic stewardship (the effort to measure and improve how antibiotics are prescribed by clinicians and used by patients) and personal protective equipment (PPE) related to enhanced barrier precautions (EBP; refers to an infection control intervention designed to reduce the transmission of multidrug-resistant organisms [MDRO] that employs targeted gown and glove use during high contact resident care activities).</p> <p>Findings are as follows:</p> <p>A. Record review of the document titled Quality Assurance and Performance Improvement Projects (QAPI) Infection Control/Education Topic: HH [hand hygiene]/PPE, dated 11/12/2024 through 3/14/2025, revealed that, relative to infection control, the facility would be monitoring hand hygiene and PPE compliance. Further review failed to reveal evidence of implementation or maintenance of the plan, including tracking and measuring performance, and establishing goals and thresholds for performance measurements.</p> <p>During surveyor observations from 3/18/2025 through 3/20/2025, for Resident ID #s 15, 60, 74 and 92, revealed that staff were observed to have a breach in infection control practices related to staff failing to wear gowns during high contact care activities for a resident on EBP.</p> <p>B. Additional review of the document titled Quality Assurance and Performance Improvement Projects (QAPI) Infection Control/Education Topic: Antibiotic Stewardship, revealed that, relative to infection control, the facility would be monitoring antibiotic stewardship compliance. Further review failed to reveal evidence of implementation or maintenance of the plan, including tracking and measuring performance, and establishing goals and thresholds for performance measurement.</p> <p>Record review for Resident ID #s 43, 64, 89, 92, and 93 failed to reveal evidence that antibiotic time outs were completed.</p> <p>During a surveyor interview on 3/21/2025 at approximately 2:30 PM with the Director of Nursing Services and the Administrator, they were unable to provide evidence of a good faith attempt to correct the identified concerns brought forth related to EBP and antibiotic stewardship.</p> <p>Cross Reference F 880 and F 881.</p> <p>46539</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46539</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections, relative to enhanced barrier precautions (EBP; refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO] that employs targeted gown and glove use during high contact resident care activities), for 4 of 4 residents reviewed on EBP, Resident ID #s 15, 60, 74, and 92.</p> <p>Findings are as follows:</p> <p>Review of the facility signage titled Enhanced Barrier Precautions states in part, .Wear Gown and Gloves prior to these activities .Dressing .bathing .transferring .providing hygiene .Device care or use of a device (i. e. central lines (a long, flexible tube that inserted into a vein in the neck, chest, arm or groin, and passed through until it reaches a large vein near the heart), urinary catheters, feeding tubes, tracheostomies (an opening a surgeon makes through your neck and into your trachea [windpipe] to help you breathe), ventilators .</p> <p>1. Record review revealed Resident ID #15 was readmitted to the facility in March of 2024 with a diagnosis including, but not limited to, chronic respiratory failure with hypoxia (low levels of oxygen in the body).</p> <p>Record review revealed that Resident ID #15 requires EBP for a gastrostomy tube (G-tube; a tube inserted through the belly, providing direct access to the stomach), tracheostomy (trach) and a history of an MDRO.</p> <p>During surveyor observations on 3/18/2025 and 3/19/2025, revealed signage posted outside of Resident ID #15's room for EBP.</p> <p>During a surveyor observation on 3/19/2025 at 9:33 AM, revealed Respiratory Therapist, Staff I, removing Resident ID #15's nebulizer treatment attached to his/her trach without wearing a gown per the facility signage.</p> <p>During a surveyor interview immediately following the above observation, with Staff I, she acknowledged that she failed to wear a gown per the signage.</p> <p>2. Record review revealed Resident ID #60 was readmitted to the facility in September of 2024 with a diagnosis including, but not limited to, chronic obstructive pulmonary disease (COPD, a common lung disease causing restricted airflow and breathing problems).</p> <p>Record review revealed that Resident ID #60 requires EBP for a G-tube, Trach, urinary catheter, and a history of an MDRO.</p> <p>During surveyor observations on 3/18/2025 and 3/19/2025, revealed signage posted outside of Resident ID #60's room for EBP.</p> <p>(continued on next page)</p>		

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

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a surveyor observation on 3/19/2025 at 9:50 AM, with Nursing Assistant (NA), Staff J, she was observed providing a bed bath for Resident ID #60 without wearing a gown per the facility signage.</p> <p>During a surveyor interview immediately following the above observation, with Staff J, she acknowledged that she failed to wear a gown per the signage.</p> <p>3. Record review revealed Resident ID #74 was readmitted to the facility in April of 2024 with a diagnosis including, but not limited to, chronic respiratory failure with hypoxia.</p> <p>Record review revealed that Resident ID #74 requires EBP for a G-Tube and Trach.</p> <p>During surveyor observations on 3/18/2025 and 3/19/2025, revealed signage posted outside of Resident ID #74's room for EBP.</p> <p>During a surveyor observation on 3/18/2025 at 9:55 AM with NA, Staff B, she was observed transferring Resident ID #74 from his/her bed to his/her chair. Staff B failed to wear a gown per the facility signage.</p> <p>During a surveyor interview immediately following the above observation, Staff B revealed that Resident ID #74 does not require the use of a gown for transfers as s/he is not on contact precautions, although the signage posted stated otherwise.</p> <p>During a surveyor observation on 3/19/2025 at 9:26 AM with NA Staff J, she was observed providing hygiene for Resident ID #74 without wearing a gown.</p> <p>During a surveyor interview immediately following the above observation, with Staff J, she acknowledged that she did not wear a gown per the facility signage and stated that Resident ID #74 did not require the use of a gown for hygiene.</p> <p>4. Record review revealed that Resident ID #92 was admitted to the facility in January of 2025, with a diagnosis including, but not limited to, chronic respiratory failure with hypoxia.</p> <p>Record review revealed that Resident ID #92 requires EBP for a G-tube, trach, and wounds.</p> <p>Additional record review revealed that Resident ID #92 has a central line.</p> <p>During surveyor observations on 3/18/2025, 3/19/2025, and 3/20/2025, revealed signage posted outside of Resident ID #92's room for EBP.</p> <p>During a surveyor observation on 3/20/2025 at approximately 8:24 AM, with Registered Nurse (RN), Staff K, she was observed to flush the resident's central line and connect the resident's antibiotic to the central line without wearing a gown. She was then observed to administer Resident ID #92 his/her medication via his/her G-Tube without wearing a gown.</p> <p>During a surveyor interview on 3/20/2025 at 9:18 AM, immediately following the above observations, Staff K revealed that she was unaware that Resident ID #92 was on EBP and that she was unsure if she should have worn a gown for G-tube or central line care.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a surveyor interview on 3/19/2025 at 11:45 AM with RN, Staff L, he revealed that when a resident has signage for EBP, he would expect staff to wear a gown when transferring, providing personal hygiene, bathing, trach care, G-Tube and central line medication administration.</p> <p>During surveyor interviews on 3/20/2025 at 9:10 AM and 3/21/2025 at 2:40 PM, with the Infection Preventionist, she revealed that she would expect staff to wear a gown when a resident is on EBP, for transferring, personal hygiene, bathing, trach care, G-Tube and central line medication administration.</p> <p>During a surveyor interview on 3/20/2025 at 9:10 AM with the Director of Nursing Services, the Infection Preventionist, and the Administrator, they revealed that they would expect staff to follow the signage posted for residents on EBP.</p> <p>Cross Reference F 865.</p> <p>50004</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement a program that monitors antibiotic use.</p> <p>46539</p> <p>Based on record review and staff interview, it has been determined that the facility failed to establish an Infection Prevention and Control Program (IPCP) that must include, at a minimum, an antibiotic stewardship program which includes antibiotic use protocols and a system to monitor antibiotic use to ensure that residents who require an antibiotic, are prescribed the appropriate antibiotic for 2 of 5 residents reviewed for antibiotic orders, Resident ID #s 89 and 93.</p> <p>Findings are as follows:</p> <p>According to the Centers for Disease Control and Prevention (CDC) document titled, The Core Elements of Antibiotic Stewardship for Nursing Homes states in part, Standardize the practices which should be applied during the care of any resident suspected of an infection or started on an antibiotic. These practices include improving the evaluation and communication of clinical signs and symptoms when a resident is first suspected of having an infection, optimizing the use of diagnostic testing, and implementing an antibiotic review process, also known as an antibiotic time-out, for all antibiotics prescribed in your facility. Antibiotic reviews provide clinicians with an opportunity to reassess the ongoing need for and choice of an antibiotic when the clinical picture is clearer and more information is available .Track the amount of antibiotic used in your nursing home to review patterns of use and determine the impact of new stewardship interventions . Interventions designed to shorten the duration of antibiotic courses, or discontinue antibiotics based on post-prescription review (i.e., antibiotic time-out), may not necessarily change the rate of antibiotic starts, but would decrease the antibiotic DOT [days of therapy] .</p> <p>1. Record review revealed that Resident ID #89 was admitted to the facility in January of 2025 with a diagnosis including, but not limited to, severe sepsis with septic shock.</p> <p>Record review revealed a physician's order for Levofloxacin (an antibiotic) tablet 750 mg give 1 tablet by mouth one time a day for prophylactics with no end date.</p> <p>Record review failed to reveal evidence of an antibiotic review or an antibiotic time out.</p> <p>Record review revealed a physician's order for Meropenem-Sodium Chloride Intravenous Solution (an antibiotic) give 1 gram intravenously every 8 hours for left hip osteomyelitis (infection in the bone) with a start date of 1/30/2025 and an end date of 3/18/2025.</p> <p>Record review failed to reveal evidence of an antibiotic review or an antibiotic time out.</p> <p>2. Record review revealed that Resident ID #93 was admitted to the facility in January of 2025 with a diagnosis including, but not limited to, bacterial pneumonia.</p> <p>Review of the hospital discharge summary dated 1/1/2025, which revealed an order for doxycycline (an antibiotic) give 100 mg by mouth two times a day for pneumonia for 2 days.</p> <p>Record review revealed a physician's order for doxycycline, give 100 mg by mouth two times a day for pneumonia for with a start date of 1/7/2025 without an end date.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the January 2025 Medication Administration Record, revealed a physician's order dated 1/13/2025 to follow-up with continuation of doxycycline 100 mg twice a day, documented as administered.</p> <p>During a surveyor interview on 3/21/2025 at 4:16 PM with Resident ID #93's Physician, he revealed that normally he would follow the hospital discharge summary recommendations unless clinical presentation indicated to continue.</p> <p>Additionally, the facility was unable to provide evidence that the physician was notified of the discharge summary which resulted in the resident receiving the doxycycline 100 mg twice a day from 1/7/2025 through 3/19/2025 for a total of 141 doses and not the 4 doses as ordered on the discharge summary.</p> <p>During a surveyor interview on 3/21/2025 at 10:15 AM, with the Director of Nursing, he acknowledged that the doxycycline 100 mg had an end date indicated on the discharge summary.</p> <p>During multiple surveyor interviews with the Infection Preventionist on 3/20/2025 and 3/21/2025, she was unable to provide evidence of antibiotic time outs being completed for the above-mentioned residents.</p> <p>During a surveyor interview on 3/21/2025 at approximately 2:30 PM with the Director of Nursing Services and the Administrator they were unable to provide evidence that antibiotic time outs had been completed for the above-mentioned residents receiving antibiotics.</p> <p>Cross reference F 856 and F 757.</p> <p>47939</p>		