

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415080	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2024
NAME OF PROVIDER OR SUPPLIER Bayberry Commons		STREET ADDRESS, CITY, STATE, ZIP CODE 181 Davis Drive Pascoag, RI 02859	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45855</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that residents receive assistance devices to prevent accidents for 1 of 2 residents reviewed who utilize hip protectors, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Review of the facility reported incident submitted to the Rhode Island Department of Health on 8/1/2024 states in part, Resident was ambulating with staff in the hallway. [S/he] tripped, lost [his/her] balance and fell to the floor. [S/he] was transferred to [hospital's] emergency department and subsequently admitted with a diagnosis of R [right] femur fracture.</p> <p>Record review revealed the resident was admitted to the facility in April of 2024 with diagnoses including, but not limited to, altered mental status, syncope, and collapse.</p> <p>Record review revealed a physician's order dated 5/3/2024 to Encourage hip protectors at all times, may remove for care.</p> <p>Record review of a facility document titled Fall Reduction Plan and Protocol last reviewed on 2/6/2024 states in part,</p> <p>.4. Any resident who has been identified and care planned as a 'high risk for falls' and/or has a known history of falls, will be offered hip protector pads (such as: 'hipsters') as an intervention in minimizing the risk of fractured hip(s). Education will be provided to the Resident and/or Representative regarding the hip protectors; this will be documented in the medical record.</p> <p>- If the Resident declines the hip protectors, the progress notes must indicate that the Resident and/or Representative were educated about the benefits of the pads (but declined) .</p> <p>Record review of the 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>Record review of a facility document titled Fall Risk Observation dated 5/31/2024 revealed that the resident was assessed as a High Fall Risk.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the resident's plan of care revealed that s/he is at risk for falls related to having a history of falls, impaired cognition, the use of psychotropic medications, diagnosis of diabetes mellitus, and bowel/bladder incontinence. S/he had an intervention to encourage hip protectors at all times and they may be removed when providing personal care.</p> <p>Record review of a progress notes dated 7/31/2024 at 8:40 PM, revealed in part, Resident is alert and confused at [his/her] baseline. Resident was ambulating with a walker with certified nursing assistant when resident trip and fall down to the floor around 8:40pm. Resident landed in right hip. Resident is complaining of pain and discomfort, resident was unable to ambulate due to pain .Resident went to the hospital via 911. Resident went to [hospital] per rescue.</p> <p>Record review of the June 2024 Treatment Administration History revealed the above order was signed off as not being completed due to the item being unavailable by Licensed Practical Nurse (LPN), Staff A, on 7/31/2024 for second shift, 3:00 PM - 11:00 PM.</p> <p>During a surveyor interview on 8/5/2024 at 11:00 AM with Staff A, she revealed that she was one of the nurses who responded when the resident fell to the floor on 7/31/2024. Additionally, she indicated that she was unable to remember if the resident was wearing hip protectors when s/he fell . Furthermore, she revealed that if she had signed off the hip protectors as being unavailable in the resident's record, then the resident was not wearing them at that time as they may have been soiled as the resident is incontinent. Staff A then reviewed Resident ID # 1's record with the surveyor and acknowledged that she charted in the resident's record that s/he was not wearing the hip protectors on 7/31/2024, when s/he fell .</p> <p>Record review of the progress notes for 7/31/2024 failed to reveal evidence that the resident refused to wear the hip protectors.</p> <p>Record review of the Emergency Department progress notes dated 7/31/2024 at 11:42 PM, revealed the resident was diagnosed with a closed comminuted displaced right intertrochanteric fracture (a broken hip).</p> <p>During a surveyor interview on 8/5/2024 at approximately 12:30 PM with the Director of Nursing Services, he was unable to provide evidence that the resident was provided with hip protectors to prevent an accident that resulted in a broken hip when s/he fell on [DATE].</p> <p>The facility's failure to provide the resident with the intervention that they developed to protect them from injuries, as a result of him/her being identified as a high fall risk, resulted in the resident sustaining a broken hip on 7/31/2024.</p>		