STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmhurst Rehabilitation & Healthcare Center	50 Maude Street Providence, RI 02908

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 0578 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 45263 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to honor a resident's right to refuse treatment, for 1 of 1 resident reviewed, Resident ID #39. Findings are as follows: Review of a community reported complaint received by the Rhode Island Department of Health on 8/19/2024 alleges that Resident ID #39 received a medication for 3 days, without his/her consent. Record review revealed the resident was admitted to the facility in June of 2023 with diagnoses including, but not limited to, cervical disc degeneration, morbid obesity, and hypertensive kidney disease. Review of a Brief Interview for Mental Status Assessment completed on 6/5/2024 revealed a score of 15 out of 15, indicating s/he is cognitively intact. Record review revealed an order dated 8/15/2024 for Trazodone (an antidepressant medication) 50 milligrams (mg) with instructions to Give 0.5 tablet by mouth three times a day for Anger and Irritability until 8/28/2024 AS Needed Only for Anger and Irritability. Record review of the August 2024 Medication Administration Record (MAR) revealed the resident received Trazodone scheduled (routinely, not as needed) on the following dates and times: 8/15/2024 at 5:00 PM 8/16/2024 at 9:00 AM, 1:00 PM, and 5:00 PM 8/17/2024 at 9:00 AM, 1:00 PM, and 5:00 PM 8/18/2024 at 9:00 AM, 1:00 PM 8/19/2024 at 9:00 AM (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Actual harm Residents Affected - Few	Further review of the August 2024 MAR revealed the resident was documented as refusing his/her dose of Trazodone on 8/18/2024 at 5:00 PM. Additionally, the Trazodone order was discontinued on 8/19/2024. During a surveyor interview on 8/22/2024 at approximately 12:40 PM, with Registered Nurse, Staff J, she revealed that the resident blew up because s/he received the wrong food and that a Nursing Assistant rolled their eyes at him/her, causing the resident to throw his/her food across his/her room. She further revealed that the psychiatric provider was contacted and came to the facility to assess the resident, which is when the Trazodone was ordered. During a surveyor interview on 8/22/2024 at approximately 12:45 PM, with the resident, s/he indicated that s/he recently became frustrated when s/he was served the incorrect meal while recovering from COVID and was kept in isolation in his/her room. The resident revealed that s/he had thrown a meal tray and a cell phone across the room on 8/12/2024. Following this incident, s/he revealed that a Nurse Practitioner (NP) came in to speak with him/her regarding his/her behaviors and indicated she was going to prescribe him/her Trazodone (a medication that is prescribed to treat depression and to help stabilize mood) to help with his/her anger. The resident revealed that s/he told the NP that s/he did not want to take Trazodone and the NP ordered Trazodone anyway. The resident further revealed that despite him/her stating that s/he did not want the medication, it was given to him/her for three days without his/her knowledge. Additionally, the resident revealed that it was on 8/18/2024 when s/he was noticed a pill that s/he did not recognize and asked the nurse what it was, that is when s/he found out that s/he had been receiving Trazodone for three times a day for three days, which made sense to him/her as s/he was unable to go outside and enjoy the sunshine due to being too sleepy and lethargic during that time. During a surveyor interview on 8/22/2024 at approximately 12:45 PM, with NP, Staff K, she revealed that when she saw the resident on 8/15/2024, the resident became angry when she discussed placing him/her on Trazodone, so she left the resident's room and did not return to further discuss prescribing him/her the medication. Additionally, she revealed that she prescribed the Trazodone to be administered as needed and not to be administered to the resident as a scheduled medication three times daily. Furthermore, she acknowledged that she had entered the order for Trazodone herself into the resident's electronic medical record. During a surveyor interview on 8/22/2024 at approximately 1:20 PM with the Director of Nursing Services, she revealed that the expectation is that the resident would have been educated and informed of the medication s/he was being prescribed and administered. She further revealed it is the resident's right to know and consent to treatment.

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NAME OF PROVIDER OR SUPPLIER: Elmhurst Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 50 Maude Street Providence, RI 02908	

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 46539 Based on surveyor observation, record review, staff, and resident interview, it has been determined that the facility failed to ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence and prevent a urinary tract infection (UTI), for 1 of 1 resident reviewed for continence, Resident ID #539. The facility further failed to provide appropriate treatment and services for 2 of 3 resident's reviewed with a suprapubic catheter (SP catheter - a device inserted through the abdomen into the bladder to drain urine), Resident ID #s 10 and 68. Findings are as follows: 1a. Record review revealed that Resident ID #539 was admitted to the facility in August of 2024 with a diagnosis including, but not limited to, left knee arthroplasty (a surgical procedure to resurface a knee damaged by arthritis). Record review of a facility policy titled, Urinary Incontinence- Clinical Protocol last revised April 2018 states in part, .As part of the initial assessment, the physician will help identify individuals with impaired urinary continence, i.e., reduced ability to maintain urine in a socially appropriate manner .The staff will identify environmental interventions and assistive devices (e.g., grab bars, raised toilet seats, bedside commodes, urinals, bed rails, restraints, and/or walkers) that facilitate toileting . Record review of a facility assessment titled, PDPM [Patient Driven Payment Model] Nursing Daily SKILLED Pathway-V4 dated 8/2/2024, revealed that the resident was continent of bladder and bowel and utilized the toilet, bed pan, pads and a brief. Record review of a hospital document dated 8/2/2024, titled General Discharge Instructions, revealed the resident was continent of bladder and bowel. During a surveyor observation on 8/7/2024 at approximately 12:30 PM of the resident's room revealed that there was not a commode or bed pan available for the resident to use in his/her room. During a surveyor interview immediately following the above observation with the resident, s/he revealed that s/he was not incontinent prior to being admitted to the facility. S/he further revealed that s/he would require two staff for assistance and a bedside commode or bedpan due to his/her recent left knee surgery. During a surveyor interview with Licensed Practical Nurse (LPN), Staff C, on 8/7/2024 at 1:43 PM, she revealed that the resident was continent, and she would now get a commode for the resident's room. During a surveyor interview with the Director of Nursing Services (DNS) on 8/7/2024 at approximately 2:00 PM, she acknowledged that the resident was continent per the assessment completed on 8/2/2024. (continued on next page)

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F 0690

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

1b. Record review of a progress dated 8/5/2024 authored by the facility's physician, Staff B, states in part, . has burning on urination that is new after leaving the hospital. Will check UA [urine analysis; a test that examines a urine sample for its physical properties, cells, and chemical composition] and culture .

Record review of a physician's order dated 8/5/2024, revealed an order to obtain UA and a culture.

Record review of the August Treatment Administration Record revealed that the above order was signed off by the facility's staff on 8/5 and 8/6/2024.

Further record review failed to reveal evidence that the UA was obtained.

During a surveyor interview with the resident on 8/7/2024 at approximately 12:30 PM, s/he revealed that s/he was in a lot of pain. S/he described that it burns when s/he urinates and thinks it is a UTI and was concerned that the facility had not obtained a urine sample.

During a surveyor interview with, LPN, Staff C, on 8/7/2024 at 1:43 PM, she revealed that she was unaware that the UA was not obtained. She further revealed that she would have to get a commode and a urinary collection device to obtain the urine.

During a surveyor interview on 8/7/2024 at approximately 2:00 PM with the DNS, she revealed that the nurse who receives the order for the UA should enter it into the resident's record and obtain the UA as soon as possible. Additionally, she was unable to explain why it was signed off and not obtained.

During a surveyor interview on 8/9/2024 at 12:02 PM with the facility's Laboratory Service Technician, she revealed that the results from the UA that were obtained on 8/7/2024 were positive for a UTI.

2. Record review revealed Resident ID #10 was admitted to the facility in June of 2020 with diagnoses including, but not limited to, urinary retention and neuromuscular dysfunction of the bladder (a condition that affects bladder function due to neurological injury or disease). Additionally, the resident was readmitted to the facility in February of 2024 following a hospitalization for sepsis (a life-threatening condition in which your body improperly responds to an infection) due to a UTI.

Review of the care plan revealed a focus area dated 5/14/2023 that indicated the resident has an SP catheter related to urinary retention and neurogenic bladder (urinary bladder problems due to disease or injury).

Review of document titled, Continuity of Care Consultation and Referral Form dated 8/1/2023 revealed that the resident was seen by his/her urologist with orders to follow up in 1 year.

During a surveyor interview on 8/9/2024 at 9:16 AM with the Unit Manager, LPN, Staff E, she revealed that she was unaware when the resident had last followed up with his/her urologist. Further, in the presence of the surveyor, Staff E contacted the resident's urology office and was informed that the resident had missed his/her annual urology appointment which was on 8/2/2024. Additionally, Staff E revealed that she was unaware that the resident had an appointment on 8/2/2024.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 8/9/2024 at 9:39 AM with the Scheduler, Staff F, she revealed that she was unaware that the resident had an appointment scheduled on 8/2/2024. She further revealed that it is the nurse's responsibility to communicate to her when a resident has an appointment, so she can arrange transportation. During a surveyor interview on 8/9/2024 at 11:52 AM with the DNS, she revealed that she would have expected that the resident would have gone to his/her urology appointment and was unable to explain why the resident missed his/her appointment on 8/2/2024. 3. Record review revealed that Resident ID #68 was readmitted to the facility in November of 2022 with a diagnosis including, but not limited to, benign prostatic hyperplasia (a condition in which the flow of urine is blocked due to the enlargement of the prostate gland). Record review of a physician's order dated 11/17/2023 revealed an order for a SP catheter. Review of a care plan focus area dated 11/18/2023 revealed that the resident requires an SP catheter, with an intervention to change the catheter as indicated and as ordered. Review of a document titled, Continuity of Care Consultation and Referral Form dated 5/2/2024 revealed that the resident was seen by his/her urologist with orders to change catheter every 4 weeks. Record review of the Physician's orders failed to reveal evidence of the order to change the resident SP catheter every 4 weeks, was transcribed. Further record review failed to reveal evidence that the resident has had his/her catheter changed per the urologist's order until July 2024, when the resident had pulled out the catheter, requiring him/her to be sent to the hospital. During a surveyor interview on 8/9/2024 at 8:21 AM with the DNS, she was unable to provide evidence that the catheter was changed every 4 weeks per the urologist's orders. 47279 50004