

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415085	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Mount St Rita Health Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 15 Sumner Brown Road Cumberland, RI 02864	

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47279</p> <p>Based on surveyor observation, record review, resident and staff interviews, it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice relative to the use of a wandguard bracelet (an electronic device used to alert staff of a potential elopement attempt) for 1 of 1 resident reviewed, Resident ID #56, and 2 of 2 residents reviewed for a change in condition, Resident ID #s 60 and 280.</p> <p>Findings are as follows:</p> <p>1. Review of a facility policy titled, Elopement Prevention Policy and Procedure states in part, .Residents with cognitive deficits can be at risk for elopement due to certain behaviors which are exit seeking, wandering or curiosity of their surroundings. There are many interventions that are utilized to prevent elopement .If these interventions are not effective the resident could benefit from a wandguard alert bracelet. This bracelet will prevent the resident from using the elevators and getting out the front lobby doors. Residents with wandguard bracelets will have .an order in their medical record for the wandguard bracelet .</p> <p>Record review revealed Resident ID #56 was admitted to the facility in July of 2023 with a diagnosis including, but not limited to, dementia. Additionally, the resident resides on an unsecured unit.</p> <p>Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating moderately impaired cognition.</p> <p>Review of a care plan focus area initiated on 6/26/2024 and last revised on 9/24/2024 revealed that the resident is at risk for wandering/elopement related to dementia and disorientation with interventions including, but not limited to, ensure wandguard function weekly and placement to the resident's walker.</p> <p>Review of a document titled, Elopement Evaluation dated 3/20/2024 revealed that the resident is at risk for elopement.</p> <p>Review of the following progress notes revealed that the resident was exhibiting wandering and exit seeking behaviors:</p> <p>- 5/28/2024: Resident with increased confusion and wandering</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 6/19/2024: Resident continuously wandering and attempting to access the elevator</p> <p>- 6/20/2024: Resident continuously wandering</p> <p>- 6/21/2024: Resident wandering at the beginning of the shift</p> <p>- 7/2/2024: Resident wandered to another floor and was redirected back to his/her floor</p> <p>- 7/24/2024: Resident continues to remove his/her wanderguard and his/her family continues to encourage the resident to keep his/her wanderguard in place to maximize safety due to his/her wandering and occasional exit-seeking behaviors</p> <p>Record review failed to reveal evidence of an order for a wanderguard per the facility policy or orders to check placement and function of the resident's wanderguard per Resident ID #56's care plan.</p> <p>During a surveyor observation and simultaneous interview on 9/24/2024 at approximately 1:00 PM with Licensed Practical Nurse (LPN), Staff A, she acknowledged that the resident has a wanderguard to his/her walker. She revealed that residents with wanderguards have orders to check the wanderguard placement daily and its function weekly. Additionally, she acknowledged that the resident did not have orders in place for a wanderguard or to check placement or function of the wanderguard.</p> <p>During a surveyor interview on 9/24/2024 at 1:20 PM with Director of Nursing Services (DNS), she revealed that residents with wanderguards should have orders in place for the wanderguard and to check placement every shift and check function every week.</p> <p>2. Review of a facility policy titled, Physician/Representative Notification of Changes states in part, .Changes in a resident's condition must be reported to the MD [Medical Doctor] and Resident Representative (when applicable) in a timely manner .The nurse on during the shift of the resident's change in condition is responsible to make the attempt to notify MD and Representative. Communication to the oncoming nurse shall include the status of the notification and MD (and Representative) response .</p> <p>a) Record review revealed Resident ID #60 was admitted to the facility in December of 2023 with a diagnosis including, but not limited to, Alzheimer's Disease.</p> <p>Record review revealed the following progress notes indicating that the resident had a change in condition:</p> <p>- 9/20/2024: The resident's legs are both noted to have pitting edema (occurs when excess fluid builds up in the body, causing swelling; when pressure is applied to the swollen area, an indentation, will remain). Staff encouraged the resident to elevate his/her legs</p> <p>- 9/22/2024: The resident continues with pitting edema to both of his/her legs and staff continues to encourage him/her to elevate his/her legs</p> <p>Record review failed to reveal evidence that the provider was notified of the resident's pitting edema to his/her legs until brought to the facility's attention by the surveyor.</p> <p>(continued on next page)</p>		

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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>During a surveyor interview on 9/23/2024 at 12:22 PM with the resident, s/he revealed that his/her legs are swollen, and staff continues to encourage the elevation of his/her legs.</p> <p>During a surveyor observation and simultaneous interview on 9/24/2024 at 3:23 PM with LPN, Staff B, he acknowledged that the resident's legs were edematous. He revealed that the resident's legs were not edematous the last time he saw the resident's, which was approximately 2 weeks ago. He further revealed that the edema was a change in condition, and this required a notification to the provider.</p> <p>During a surveyor interview on 9/25/2024 at 9:49 AM with the Physician, he revealed that he would expect staff to have notified him when the edema was first noted. Additionally, he revealed that he implemented new interventions for the resident's edematous legs.</p> <p>During a surveyor interview on 9/25/2024 at 9:25 AM with the DNS, she acknowledged that the resident's leg edema was a change in condition and that the provider should have been notified on 9/20/2024, when the edema was first noted.</p> <p>b) Record review revealed Resident ID #280 was admitted to the facility in September of 2024 with a diagnosis including, but not limited to, iron deficiency anemia (a condition when the body lacks healthy red blood cells).</p> <p>Review of a physician's order dated 9/13/2024 indicated to monitor for bleeding every shift and notify the provider if the resident experiences any signs or symptoms of bleeding.</p> <p>Review a progress note dated 9/16/2024 at 12:09 PM authored by the Physician, revealed that the resident had 4 stents (an implanted device in a blood vessel to help restore blood flow) placed (inserted via wrists and groin) and that the resident had .no bleeding, no easy bruisability .</p> <p>Record review revealed the following progress note indicating that the resident had a change in condition:</p> <p>- 9/16/2024 at 3:42 PM: The resident was noted to have bruising all around his/her genitals and groin area and the bruising was monitored throughout the shift and reported to the oncoming nurse.</p> <p>Record review failed to reveal evidence that a provider was notified of the bruising to his/her genital and groin area.</p> <p>During a surveyor interview on 9/26/2024 at 10:46 AM with LPN, Staff C, she revealed that she was aware that the resident had stents placed through his/her groin. She further revealed that a Nursing Assistant noted the bruising to the resident's groin area and the bruising seemed like it was new. She was unable to recall if she contacted the provider.</p> <p>During a surveyor interview on 9/26/2024 at 10:53 AM with the DNS, she revealed that she would have expected staff to notify the provider when the bruising was first noted.</p> <p>During a surveyor interview on 9/26/2024 at 11:54 AM with the Physician, he revealed that he would expect staff to have notified him when the bruising was first noted.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>47279</p> <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that a resident with pressure ulcers receives the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 1 newly admitted resident reviewed with a pressure ulcer, Resident ID #280.</p> <p>Findings are as follows:</p> <p>1. Review of a facility document titled, Skin Integrity - Wound Care Protocols states in part, . DOCUMENTATION: 1. A complete wound assessment and documentation will be done weekly on all pressure ulcers until they are healed. The criteria to be included .Site/location .Stage [severity of wound] . Size .Appearance of the wound bed .Undermining/tunneling .Surrounding skin .Drainage .</p> <p>Record review revealed the resident was admitted to the facility in September of 2024 with a diagnosis including, but not limited to, pressure induced deep tissue damage of the left heel (a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure).</p> <p>Record review of the hospital discharge paperwork dated 9/13/2024 revealed that the resident was receiving daily wound treatment to his/her left heel wound.</p> <p>Review of the admission progress note dated 9/13/2024 revealed that the resident has a pressure ulcer to his/her left heel.</p> <p>Record review failed to reveal evidence that the resident received any wound care to his/her left heel wound until 9/20/2024, 7 days after the resident was admitted . Further record review failed to reveal evidence that the resident had his/her wound assessed to include the appropriate wound documentation and measurements including, but not limited to, size, appearance, surrounding skin, and drainage until the resident's wound was first assessed by the wound physician on 9/24/2024.</p> <p>During surveyor interviews on 9/25/2024 at 11:49 AM and 12:27 PM with the Unit Manager, Registered Nurse, Staff D, she revealed that the resident did not receive any treatment to his/her left heel pressure wound from 9/13 - 9/20/2024 because the treatment order was transcribed incorrectly. Additionally, she revealed that no wound measurements or wound descriptions were completed for his/her left heel wound until 9/24/2024. Further, she revealed that she is the facility's wound nurse and would expect staff to be measuring and describing the wound upon admission and weekly thereafter.</p> <p>During a surveyor interview on 9/25/2024 at 3:33 PM with the Director of Nursing Services, she revealed that she would have expected that the resident's left heel pressure wound to have been addressed and treated, and staff to be measuring and documenting on the condition of the wound weekly.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46539</p> <p>Based on surveyor observation and staff interview, it has been determined that the facility failed to store and label drugs and biologicals in accordance with currently accepted professional principles for 1 of 3 medication carts reviewed and 3 of 3 medication rooms.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled, Medication Storage last revised on ,d+[DATE] states in part, .refrigerators should be kept clean and frost free .Outdated, contaminated, discontinued or deteriorated medications .are immediately removed from stock .</p> <p>1. During a surveyor observation of the 1st floor medication cart on [DATE] at 9:40 AM, in the presence of Licensed Practical Nurse (LPN), Staff C, revealed the following:</p> <ul style="list-style-type: none"> - 1 bottle of vitamin B complex with Vitamin C with a manufacturer's expiration date of ,d+[DATE] - 1 bottle of cranberry supplement with a manufacturer's expiration date of ,d+[DATE] - 1 bottle of ferate 27 milligram (mg) tablets with a manufacturer's expiration date of ,d+[DATE] - 1 bottle of aspirin 81 mg tablets with a manufacturer's expiration date of ,d+[DATE] - 1 bottle of a multivitamin one daily with a manufacturer's expiration date of ,d+[DATE] <p>During a surveyor interview immediately following the observation with Staff C, she acknowledged that the above-mentioned medications were expired and should have been discarded.</p> <p>2. During a surveyor observation on [DATE] at 10:08 AM of the 2nd floor medication room in the presence of LPN, Staff E, revealed one bottle of liquid Ativan Intensol with a manufacturer's instructions to discard opened bottles after 90 days, with an open date of [DATE] and an expiration date of [DATE].</p> <p>During a surveyor interview immediately following the above observation with Staff E, she acknowledged that the Ativan Intensol was opened and expired.</p> <p>3. During a surveyor observation on [DATE] at 10:46 AM of the 3rd floor Medication Room in the presence of LPN, Staff A, revealed one bottle of liquid Ativan Intensol with a manufacturer's instructions to discard opened bottles after 90 days, with an open date of [DATE] and an expiration date of [DATE].</p> <p>During a surveyor interview immediately following the above observation with Staff A, she acknowledged that the Ativan Intensol was opened and expired.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. During a surveyor observation on [DATE] at 9:51 AM of the 1st floor medication storage fridge revealed an accumulation of ice in the freezer.</p> <p>During a surveyor interview with Staff C, at the time of the above observation, she acknowledged that there was an accumulation of ice in the freezer.</p> <p>5. During a surveyor observation on [DATE] at 10:08 AM of the 2nd floor medication storage fridge revealed an accumulation of ice in the freezer</p> <p>During a surveyor interview with Staff E, at the time of the above observation, she acknowledged that there was an accumulation of ice in the freezer.</p> <p>6. During a surveyor observation on [DATE] at 10:46 AM of the 3rd floor medication storage fridge revealed an accumulation of ice in the freezer.</p> <p>During a surveyor interview with Staff A, at the time of the above observation, she acknowledged that there was an accumulation of ice in the freezer.</p> <p>During a surveyor interview on [DATE] at 12:57 PM with the Director of Nursing Services, she revealed that she would expect the staff to discard medications appropriately when they are expired. Additionally, she revealed that there should not be a accumulation of ice in the freezers and was unsure of the last time they were defrosted.</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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 that includes antibiotic use protocols and a system to monitor antibiotic use for 1 of 3 residents reviewed on antibiotics, Resident ID #280.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled, Antimicrobial Stewardship Program Long Term Care dated 1/1/2024-12/31/2024 states in part, .Nursing staff will receive antibiotic use and infection status information of a patient/resident who is being transferred into the healthcare facility. An antibiotic timeout will be performed within 72 hours of prescribing .</p> <p>Record review revealed that the resident was admitted to the facility in September 2024 with diagnoses including, but not limited to, pressure-induced deep tissue damage of the left heel (a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure) and peripheral vascular disease (a condition when narrowed arteries reduce blood flow to the arms or legs).</p> <p>Review of a Hospital Discharge Summary dated 9/13/2024 revealed an order for Bactroban 2% (topical antibiotic) topically three times a day for 30 days. Further review failed to reveal evidence on where staff should apply the medication.</p> <p>Review of an Internal Medicine Progress Note dated 9/13/2024 revealed Bactroban 2% ordered for a left heel wound.</p> <p>Review of the September 2024 Treatment Administration Record revealed the Bactroban was signed off as administered to the resident's nares three times a day for 11 days.</p> <p>Record review failed to reveal evidence that the facility performed an antibiotic time out.</p> <p>During a surveyor interview with the Infection Preventionist (IP) on 9/25/2024 at 10:24 AM, she acknowledged that the hospital paperwork revealed that the Bactroban was ordered for a left heel wound. Additionally, she acknowledged that there was no indication to apply the Bactroban to the nares. Further, the IP acknowledged that an antibiotic time out was not completed.</p> <p>During a surveyor interview on 9/25/2024 at 3:33 PM with the Director of Nursing Services she acknowledged that the resident received the antibiotic to the nares and not the left heel wound as ordered. Additionally, she acknowledged an antibiotic timeout was not completed for the resident and the Bactroban use.</p>		