

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415087	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2024
NAME OF PROVIDER OR SUPPLIER Greenville Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 735 Putnam Pike Greenville, RI 02828	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21613</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to treat each resident with respect and dignity in a manner and in an environment that promotes maintenance of his or her quality of life, for 2 of 2 residents reviewed, Resident ID #s 2 and 7.</p> <p>Findings are as follows:</p> <p>1. Review of a facility reported incident submitted to the Rhode Island Department of Health on 4/26/2024 revealed that a Nursing Assistant (NA), Staff B, reported an allegation of abuse that occurred on 4/24/2024 involving Resident ID #2.</p> <p>During a surveyor observation of video footage from 4/24/2024 at 9:48 PM, revealed the resident was seated upright in a recliner chair, with the wall on his/her left side and a table on his/her right side. Additionally, a chair was placed in front of the elevated footrest, preventing the footrest of the recliner from releasing and another resident (Resident ID #7) was noted to be lying in a recliner behind Resident ID #2's recliner chair.</p> <p>Additional, review of the video footage from 4/24/2024 at 9:48 PM, revealed Resident ID #2 was lying in a recliner chair in the day room, wearing only a hospital gown. Subsequently, Resident ID #2 was taken out of the day room and into the hallway by NA, Staff D, where it was noted that the resident's upper thighs and legs were not covered, exposing his/her thighs and legs, while in the recliner chair. The video footage failed to reveal that Staff D attempted to cover the resident's thighs and legs while transporting her/him in the recliner chair.</p> <p>Furthermore, during the review of the video footage from 4/24/2024 at 9:58 PM, revealed Staff D transporting Resident ID #2 back into the day room, in a wheelchair. Staff D aggressively grabs both of Resident ID #2's arms and holds them up so that Certified Medication Technician, Staff E, can push a table against Resident ID #2's chest. At this time, Staff D was noted to push the table again, causing the table to be wedged between the resident and a support column.</p> <p>Record review revealed Resident ID #2 was admitted to the facility in March of 2024 with diagnoses including, but not limited to, dementia and cognitive communication deficit.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS, an assessment used to determine cognition) was unable to be completed due to the resident being rarely/never understood, indicating that s/he is severely cognitively impaired.</p> <p>A surveyor observation on 5/2/2024 at 2:15 PM, revealed the resident was sitting in his/her wheelchair in the day room. The surveyor attempted to interview the resident at the time of this observation, but the resident was unable to answer any questions due to severe cognitive impairment.</p> <p>2. During an additional observation of the video footage from 4/24/2024 at approximately 9:30 PM through 10:30 PM, it was revealed that Resident ID #7 was noted to be laying in a recliner chair in the day room (behind Resident ID #2's recliner chair). Throughout this time, it was noted that Resident ID #7 appeared to be in and out of sleep, with his/her head hanging over the side of the recliner chair.</p> <p>Record review revealed Resident ID #7 was readmitted to the facility in February of 2024 with diagnoses including, but not limited to, dementia, cerebral infarction (stroke) and agitation.</p> <p>Review of an admission MDS assessment dated [DATE] revealed a BIMS Assessment was unable to be completed due to the resident being rarely/never understood, indicating that s/he is severely cognitively impaired.</p> <p>A surveyor observation on 5/2/2024 at 2:05 PM revealed the resident was lying in his/her recliner chair in the day room. The surveyor attempted to interview the resident at the time of the observation, but the resident was unable to answer any questions due to his/her severe cognitive impairment.</p> <p>During a surveyor interview with Licensed Practical Nurse, Staff A, on 5/3/2024 at 9:46 AM, she revealed that she works full time on the secured memory care unit on the 3:00 PM through 11:00 PM shift. She further revealed that Resident ID #'s 2 and 7 have dementia and all their needs must be anticipated by staff. She indicated that they are kept in the unit's day room during her shift for safety reasons as staff do not properly monitor the residents especially when they are on their phones.</p> <p>During a surveyor interview with NA, Staff I, on 5/3/2024 at 12:45 PM, he revealed that he works full time on the memory care unit, on the 11:00 PM to 7:00 AM shift. Staff I further revealed that when he comes into work at 11:00 PM, he usually finds Residents ID #s 2 and 7 lying in their recliner chairs in the day room.</p> <p>During a surveyor interview with NA, Staff K on 5/3/2024 at 12:56 PM, he revealed he works full time on the memory care unit, on the 3:00 PM to 11:00 PM shift. Staff K further revealed that when he comes into work at 3:00 PM, he usually finds Residents ID #s 2 and 7 lying in their recliner chairs in the day room, and indicated that they remain there until 11:00 PM, when he leaves.</p> <p>During a surveyor interview with the Administrator and the Director of Nursing Services on 5/3/2024 at 3:20 PM, they acknowledged the facility failed to treat Residents ID #s 2 and 7 in a dignified manner and in an environment that promotes maintenance of their quality of life.</p> <p>46241</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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** 46241</p> <p>Based on surveyor observation, record review, and staff interview it has been determined that the facility failed to protect the resident's right to be free from abuse for 1 of 1 resident observed for abuse, Resident ID #2.</p> <p>Findings are as follows:</p> <p>Review of a facility reported incident submitted to the Rhode Island Department of Health on 4/26/2024 revealed that Nursing Assistant (NA), Staff B, reported an allegation of abuse that occurred on 4/24/2024 between Resident ID #2 and two staff members, NA, Staff D and Certified Medication Technician (CMT), Staff E. Staff B indicated that she overheard a resident yelling out loudly followed by a bang noise around 9:30 PM.</p> <p>Review of a facility policy titled Abuse Prohibition Policy and Procedure states in part, .prohibits abuse, mistreatment, neglect .for all residents. This includes, but is not limited to, freedom from corporal punishment .any physical or chemical restraint not required to treat the patient's medical symptoms. Centers also strive to comply with the Elder Justice Act (EJA). Under the EJA, employees are designated as mandated reporters and are obligated to immediately report any suspicion of a crime against a resident .Physical Abuse includes hitting, slapping, pinching, kicking, etc., as well as controlling behavior through corporal punishment .</p> <p>Record review revealed Resident ID #2 was admitted to the facility in March of 2024 with diagnoses including, but not limited to, dementia and cognitive communication deficit.</p> <p>Review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status (an assessment used to determine cognition) was unable to be completed due to the resident being rarely/never understood, indicating that s/he is severely cognitively impaired.</p> <p>During a surveyor interview on 5/2/2024 at 12:37 PM, with the Administrator and Director of Nursing Services (DNS), they revealed that they were made aware of the allegation of abuse on 4/26/2024, when NA, Staff B asked another staff member about the incident. They indicated that they watched the video footage from 4/24/2024 around 9:30 PM, and observed NA, Staff D and CMT, Staff E physically abuse and restrain Resident ID #2, while the resident was sitting in a recliner and then a wheelchair, located in the day room of the unit.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview on 5/2/2024 at 1:25 PM, with NA, Staff B and NA, Staff C, translated by the Director Human Resources, Staff L, they revealed that on 4/24/2024 at approximately 9:30 PM, they were assisting other residents in their rooms when they both heard a female resident yelling followed by a loud bang noise coming from the day room. Staff B, revealed that she immediately went to the day room and saw NA, Staff D and CMT, Staff E standing next to Resident ID #2, while s/he was sitting in his/her recliner chair. They revealed that Staff D then took Resident ID #2 out of the day room and assisted him/her in the bathroom and then returned the resident to the day room in a wheelchair. They indicated that when Staff D brought the resident back to the day room, they observed Staff D and E push a table up against the resident, while s/he was sitting in a wheelchair, with his/her back against the wall.</p> <p>A surveyor observation on 5/2/2024 at 1:51 PM, of video footage from 4/24/2024 at 9:49 PM, in the presence of the Administrator and the Human Resource Director, Staff L, revealed Resident ID #2 was seated upright in a recliner chair and was observed attempting to get out of the recliner by placing his/her legs on a table, which was located directly next to the resident. Without notice, NA, Staff D, aggressively stands up and steps towards Resident ID #2 and without hesitation, Staff D uses her right arm to forcefully shove Resident ID #2 on his/her right shoulder, sending him/her backwards abruptly. Staff D then grabbed Resident ID #2's legs and yanked them to the left, continuing to push his/her legs down in an aggressive manner. Staff D was then assisted by CMT, Staff E, who was observed grabbing Resident ID #2 under his/her armpits and lifting his/her body upwards in the chair. At 9:51 PM Staff D was observed pushing the resident out of the dayroom in his/her recliner chair. At 9:58 PM Staff D pushes Resident ID #2 back into the dayroom, in a wheelchair. Resident ID #2 is holding his/her chest area as s/he reenters the room and Staff D places the resident with his/her back against the wall. Staff D aggressively grabs both of Resident ID #2's arms and holds them up so that Staff E can push a table against Resident ID #2's chest. At this time, Staff D was noted to push the table again, causing the table to be wedged between the resident and a support column.</p> <p>During a surveyor interview on 5/2/2024 at approximately 2:15 PM, with NA, Staff D, she revealed that she made a mistake and acknowledged pushing Resident ID #2 on 4/24/2024 and stated that it was not her intention to harm the resident. She further indicated that Licensed Practical Nurse, Staff A, tells staff to keep Resident ID #2 in the day room, restrained in his/her recliner, because the resident is a fall risk due to him/her attempting to get up and walk independently.</p> <p>A surveyor observation of Resident ID #2 on 5/2/2024 at approximately 2:20 PM, in the presence of LPN, Staff J, revealed s/he had scattered bruising noted to both arms.</p> <p>During a surveyor interview on 5/3/2024 at 9:22 AM with CMT, Staff E, he revealed that on 4/24/2024, Staff D called him over to assist her, after she brought the resident back to the dayroom. He acknowledged that he pulled the table close to the resident, indicating that Staff A has previously told staff to place the resident in this position, due to him/her being at risk for falls.</p> <p>During a surveyor interview on 5/3/2024 at 9:46 AM, with LPN, Staff A, she revealed that nothing out of the ordinary occurred on 4/24/2024 and indicated that she did not witness any incidents of abuse. She indicated that she has never facilitated staff to restrain the resident in the dayroom but acknowledged that she has allowed it to happen before due to a safety concern as staff do not properly monitor the residents especially when they are on their phones.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review revealed a skin assessment dated [DATE] at 10:56 PM, which revealed the resident had bruises because arms restlessness, and legs throws them over recliner.</p> <p>Record review revealed a skin assessment dated [DATE] which revealed the resident was noted to have several pea size to pinpoint bruises on his/her right and left lower arms, nickel size bruises on his/her forearms, pea size bruises on his/her wrists and hands, two small bruises on his/her right upper arm, and a bruise noted to the lower front of his/her leg.</p> <p>During a surveyor interview on 5/2/2024 at 11:58 AM and 5/3/2024 at 2:00 PM, with the Administrator and DNS, they revealed that NA, Staff D was terminated following this incident and CMT, Staff E was suspended due to the incident. Additionally, they were unable to provide evidence that Resident ID #2 was kept free from physical abuse.</p> <p>21613</p>

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46241</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure residents have the right to be free from any physical restraint, not required to treat the resident's medical symptoms, for 2 of 3 residents reviewed, Resident ID #s 2 and 7.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled, .Restraints: Use of states in part, .Patients have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the patient's medical symptoms .Convenience is defined as the result of any action that has the effect of altering a patient's behavior such that the patient requires a lesser amount of effort or care, and is not in the patient's best interest .Physical Restraint is defined as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria: Is attached or adjacent to the patient's body, Cannot be removed easily by the patient, and Restricts the patient's freedom of movement or normal access to their body .Patients will be evaluated for the use of restraints or protective devices during the nursing assessment process .If the device cannot be easily removed by the patient and/or restricts freedom of movement or normal access to their body, the Restraint Evaluation/Reduction will be completed .There must be documentation identifying the medical symptom being treated and an order for the use of the specific type of restraint .Consent must be obtained prior to the application of the restraint. The patient, or patient representative if applicable, has the right to refuse the use of a restraint and may withdraw consent to use the restraint at anytime. Refusal must be documented in the medical record .</p> <p>Review of a facility reported incident submitted to the Rhode Island Department of Health on 4/26/2024 revealed that Nursing Assistant (NA), Staff B reported an allegation of abuse that occurred on 4/24/2024 between Resident ID #2 and two staff members, NA, Staff D and Certified Medication Technician (CMT), Staff E. Staff B indicated that she overheard a resident yelling out loudly followed by a bang noise around 9:30 PM.</p> <p>A surveyor observation on 5/2/2024 at 1:51 PM, of video footage from 4/24/2024 at 9:49 PM, in the presence of the Administrator and the Human Resource Director, Staff L, revealed Resident ID #2 was seated upright in a recliner chair, with the wall on his/her left side and a table on his/her right side. Additionally, a chair was placed in front of Resident ID #2's elevated footrest, preventing the footrest of the recliner from releasing. Resident ID #7 was noted to be lying in a recliner, up against the back of Resident ID #2's recliner chair. Therefore, Resident ID #2 could not safely get out of the recliner if s/he wanted to, as there was a wall on his/her left side, a table on his/her right side, a chair under his/her footrest, and another resident, Resident ID #7, directly behind him/her, sitting in a recliner. Additionally, Resident ID #7 could not safely get out of the recliner if s/he wanted to, as the resident was reclined back and would be unable to reach the foot lever, as it is located behind the recliner.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Additional surveyor observation of the video footage from 4/24/2024 at 9:51 PM, revealed that NA, Staff D was observed pushing the resident out of the room in his/her recliner chair. At 9:58 PM Staff D pushes Resident ID #2 back into the dayroom, in a wheelchair. Resident ID #2 is holding his/her chest area as s/he reenters the room and Staff D places the resident with his/her back against the wall. Staff D aggressively grabs both of Resident ID #2's arms and holds them up so that CMT, Staff E can push a table against Resident ID #2's chest. At this time, Staff D was noted to push the table again, causing the table to be wedged between the resident and a support column. Staff D then pulled Resident ID #7's recliner, towards Resident ID #2's wheelchair, so the footrest of Resident ID #7's recliner was propped up on Resident ID #2's wheelchair, preventing the recliner from returning to an upright position, not allowing Resident ID #7 to get up independently.</p> <p>1. Record review revealed Resident ID #2 was admitted to the facility in March of 2024 with diagnoses including, but not limited to, dementia and cognitive communication deficit.</p> <p>Review of a Minimum Data Set Assessment (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS, an assessment used to determine cognition) was unable to be completed due to the resident being rarely/never understood, indicating that s/he is severely cognitively impaired. Further review revealed the resident utilizes a wheelchair for mobility and requires extensive assistance for transfers by staff members.</p> <p>Record review failed to reveal evidence of any restraint assessments, consent form, physician orders, or care plan interventions, prior the incident on 4/24/2024, per the Restraints: Use of policy.</p> <p>During a surveyor interview with Licensed Practical Nurse (LPN), Staff J, on 5/2/2024 at 2:20 PM, she revealed the resident can stand up and walk but his/her gait is not steady. She further revealed that the resident can self-propel while in his/her wheelchair by moving his/her legs and feet.</p> <p>During a surveyor interview with LPN, Staff F, on 5/6/2024 at 9:30 AM, she revealed that Resident ID #2 can get up from his/her bed or his/her wheelchair if s/he wants to. Staff F further revealed that the resident can walk but only few steps without staff assistance and the resident will fall without staff assistance. Additionally, Staff F revealed that if the resident is in a recliner chair, s/he will try to get out of it.</p> <p>A surveyor observation of Resident ID #2, in the presence of Staff F on 5/6/2024 at 9:54 AM, revealed the resident was sitting in his/her wheelchair in the day room, with the left wheel in the locked position. It was noted at this time that the resident was trying to self-propel the wheelchair by using his/her feet. Staff F acknowledged that the resident's wheelchair was locked and revealed that the resident can self-propel by moving her/his feet while in his/her wheelchair if the wheelchair was not locked.</p> <p>During a surveyor interview with a NA, Staff H, on 5/6/2024 at 9:58 AM, she revealed that she has been providing care to Resident ID #2 since s/he was admitted to the facility. Staff H then revealed the resident can get up from his/her bed, his/her wheelchair, and his/her recliner chair. Staff H further revealed that the resident can walk but his/her gait is not steady, indicating that s/he can walk approximately 50 feet with assistance from staff.</p> <p>2. Record review revealed Resident ID #7 was admitted to the facility in February of 2024 with diagnoses including, but not limited to, dementia and cerebral infarction (stroke).</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of a MDS assessment dated [DATE] revealed a BIMS Assessment was unable to be completed due to the resident being rarely/never understood, indicating that s/he is severely cognitively impaired. Further review revealed the resident requires partial/moderate assistance with transfers.</p> <p>During a surveyor interview on 5/6/2024 at 9:40 AM, with LPN, Staff F, she revealed that Resident ID #7 can ambulate a few steps and indicated that at times, the resident tries to get up independently from the wheelchair or recliner chair.</p> <p>During a surveyor interview on 5/6/2024 at 10:06 AM, with NA, Staff G, she revealed that the resident can stand up on his/her own and can ambulate a few steps.</p> <p>Record review failed to reveal evidence of any restraint assessments, consent forms, physician orders, or care plan interventions prior to the incident on 4/24/2024, per the Restraints: Use of policy.</p> <p>During a surveyor interview on 5/2/2024 at 12:37 PM, with the Administrator and Director of Nursing Services (DNS), they acknowledged that Resident ID #2 was being physically restrained on 4/24/2024, by NA, Staff D and CMT, E. They acknowledged that s/he was unable to get up from the recliner chair. They further revealed that during the investigation of this incident, numerous staff have revealed that Resident ID #2 and #7 are often restrained in this manner, due to the residents being at risk for falls. They indicated that LPN, Staff A, told administration that she did, at times, have Nursing Assistants restrain residents in the day room by placing the resident in a recliner chair sideways against the wall, with a table adjacent to the resident on the other side, a chair at the foot of the recliner, as well as another resident behind them.</p> <p>During a surveyor interview on 5/2/2024 at 2:15 PM, with NA, Staff D, she revealed that Resident ID #2 is usually kept in the dining room, restrained in his/her recliner chair, due to resident being at risk for falls, because s/he tries to stand up and ambulate independently. She indicated that Staff A and other nurses have told staff to restrain the residents in this manner due to safety concerns.</p> <p>During a surveyor interview on 5/3/2024 at 9:22 AM with CMT, Staff E, he revealed that on 4/24/2024, Staff D called him over to assist her, after she brought Resident ID #2 back to the dayroom. He acknowledged that he pulled the table close to the resident, restraining him/her in the wheelchair, indicating that Staff A has previously told staff to place the resident in this position, due to him/her being at risk for falls.</p> <p>During a surveyor interview on 5/3/2024 at 9:46 AM, with LPN, Staff A, she indicated that she has never facilitated staff to restrain the resident in the dayroom but acknowledged that she has allowed it to happen in the past, because of a safety concern, indicating that staff do not properly monitor the residents especially when they are on their phones. Further, she revealed that she was unaware that restraining residents in this manner was a concern.</p> <p>During a surveyor interview on 5/2/2024 at 11:58 AM and 5/3/2024 at 2:00 PM, with the Administrator, and the DNS, they revealed that NA, Staff D was terminated following this incident and CMT, Staff E was suspended due to this incident. Additionally, they were unable to provide evidence that Resident ID #2 and #7 were kept free from physical restraints.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21613</p> <p>Based on surveyor observation, record review and staff interview it has been determined that the facility failed to provide evidence that all alleged violations of abuse are thoroughly investigated and reported to the State Survey Agency (Department of Health) for Resident ID #1 and failed to prevent further potential abuse while an investigation was in progress for Resident ID #2.</p> <p>Findings are as follows:</p> <p>Review of a facility policy and procedure revised on 10/24/2022 titled Abuse Prohibition states in part, .6. Staff will identify events .patterns, and trends that may constitute abuse .</p> <p>6.1 Anyone who witnesses an incident of suspected abuse, neglect .is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately, regardless of shift worked.</p> <p>6.1.1. The notified supervisor will report the suspected abuse immediately to the Administrator or designee and other officials in accordance with state law.</p> <p>6.1.2. The employee alleged to have committed the act of abuse will be immediately remove from duty, pending investigation.</p> <p>6.1.3. All reports of suspected abuse must also be reported to the patient's family and attending physician .</p> <p>6.2. Anyone who witnesses an incident of suspected abuse, neglect .must also report to outside agencies, if required.</p> <p>6.2.1 Staff are obligated to report reasonable suspicion of crime against the elderly to the state agency and local law enforcement .</p> <p>1. Review of a facility reported incident submitted to the Rhode Island Department of Health on 5/2/2024 revealed an allegation of abuse that occurred on 4/24/2024 during the second shift (3:00 PM-11:00 PM), before dinner, involving Resident ID #1, Nursing Assistant (NA), Staff D and Certified Medicaiton Technician (CMT), Staff E. The resident was overheard screaming help me, don't hit me, stop hitting me, you're not my mom.</p> <p>Record review revealed Resident ID #1 was admitted to the facility in May of 2023 with diagnoses including, but not limited to, dementia and anxiety disorder.</p> <p>Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS, an assessment used to determine cognition) score of 4 out of 15, indicating s/he is severely cognitively impaired.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During a surveyor interview on 5/2/2024 at 1:25 PM, with NA, Staff B and NA, Staff C, translated by the Director of Human Resources, Staff L, they revealed that on 4/24/2024, before dinner time, Staff B overheard Resident ID #1 screaming out loud in his/her room stating, help me, don't hit me, stop hitting me, you're not my mom, while Staff D and Staff E were present in the resident's room. Both Staff B and Staff C revealed that they immediately informed Licensed Practical Nurse (LPN), Staff A, of the abuse concerns with Resident ID #1.</p> <p>Record review failed to reveal evidence that this allegation of abuse involving Resident ID #1 was acted upon immediately. This failure allowed the two perpetrators, NA, Staff D and CMT, Staff E, to continue working the evening of 4/24/2024.</p> <p>Further record review failed to reveal evidence that this allegation of abuse was reported to the Administrator by LPN, Staff A, as required. Additionally, record review failed to reveal evidence of an investigation for this abuse allegation, until 5/1/2024, 7 days after the allegation occurred.</p> <p>This facility failure allowed NA, Staff D and CMT, Staff E, to continue working the evening of 4/24/2024 resulting in another abuse allegation approximately 5 hours later with Resident ID #2. This allegation of abuse was later corroborated by via footage.</p> <p>2. Review of a facility reported incident submitted to the Rhode Island Department of Health on 4/26/2024 revealed an allegation of abuse that occurred on 4/24/2024 with Resident ID #2 and two staff members, NA, Staff D and CMT, Staff E.</p> <p>Record review revealed Resident ID #2 was admitted to the facility in March of 2024 with diagnoses including, but not limited to, dementia and cognitive communication deficit.</p> <p>Review of a MDS assessment dated [DATE] revealed a BIMS Assessment was unable to be completed due to the resident being rarely/never understood, indicating that s/he is severely cognitively impaired.</p> <p>During a surveyor interview on 5/2/2024 at 12:37 PM, with the Administrator and Director of Nursing Services (DNS), they revealed that they were made aware of the allegation of abuse on 4/26/2024, when NA, Staff B asked another staff member about the incident. They indicated that they watched the video footage from 4/24/2024 around 9:30 PM and observed NA, Staff D and CMT, Staff E, physically abuse and restrain Resident ID #2, while the resident was sitting in a recliner and then wheelchair, located in the day room of the unit. Additionally, the Administrator revealed that they were not aware of the allegation of abuse relative to Resident ID #1 with Staff D and E, that occurred on 4/24/2024 until 5/1/2024, 7 days after the allegation was made.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During a surveyor interview on 5/2/2024 at 1:25 PM, with NA, Staff B and NA, Staff C, translated by the Director Human Resources, Staff L, they revealed that on 4/24/2024 at approximately 9:30 PM, they were assisting other residents in their rooms when they both heard a female resident yelling followed by a loud bang noise coming from the day room. Staff B revealed that she immediately went to the day room and saw NA, Staff D and CMT, Staff E standing next to Resident ID #2, while s/he was sitting in his/her recliner chair. They revealed that Staff D then took Resident ID #2 out of the day room and assisted him/her in the bathroom and then returned the resident to the day room in a wheelchair. They indicated that when Staff D brought the resident back to the day room, they observed Staff D holding the resident's hands, while Staff E pushed a table up against the resident, while s/he was sitting in a wheelchair, with his/her back against the wall. Further, both NA's, Staff B and C revealed that they did not report this incident with Resident ID #2 to LPN, Staff A, because they had already reported an allegation of abuse earlier in the shift concerning Resident ID #1. After they informed Staff A of the alleged incident with Resident ID #1, Staff A threw her hands in the air and shrugged her shoulders.</p> <p>During a surveyor interview on 5/3/2024 at 9:46 AM, with LPN, Staff A, she revealed that nothing out of the ordinary occurred on 4/24/2024 and indicated that she did not witness any incidents of abuse. She further revealed that no one reported any allegations of abuse to her throughout the shift on 4/24/2024. She denied that NA's, Staff B and C reported an allegation of abuse to her concerning Resident ID #1.</p> <p>During a surveyor interview on 5/2/2024 at 11:58 AM and 5/3/2024 at 2:00 PM, with the Administrator and the DNS, they were unable to provide evidence that the allegation of abuse for Resident ID #1 was investigated immediately after the allegation was reported to LPN, Staff A, which could have prevented the incident of abuse from occurring with Resident ID #2, if Na, Staff D and CMT, Staff E were removed from duty immediately.</p> <p>46241</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>46241</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that nursing staff have the appropriate skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical well-being of each resident, as determined by resident assessments and individual plans of care, relative to restraints, for 5 of 7 staff reviewed, Staff D, E, G, H, and I.</p> <p>Findings are as follows:</p> <p>Review of a facility reported incident submitted to the Rhode Island Department of Health on 4/26/2024 revealed an allegation of abuse that occurred on 4/24/2024 with Resident ID #2 and two staff members, Nursing Assistant (NA), Staff D and Certified Medication Technician (CMT), Staff E.</p> <p>A surveyor observation on 5/2/2024 at 1:51 PM, of video footage from 4/24/2024 at 9:49 PM, in the presence of the Administrator and the Human Resource Director, Staff L, revealed Resident ID #2 was seated upright in a recliner chair, with the wall on his/her left side and a table on his/her right side. Additionally, a chair was placed in front of Resident ID #2's elevated footrest, preventing the footrest of the recliner from releasing. Resident ID #7 was noted to be lying in a recliner, up against the back of Resident ID #2's recliner chair. Therefore, Resident ID #2 could not safely get out of the recliner if s/he wanted to, as there was a wall on his/her left side, a table on his/her right side, a chair under his/her footrest, and another resident, Resident ID #7, directly behind him/her, sitting in a recliner. Additionally, Resident ID #7 could not safely get out of the recliner if s/he wanted to, as the resident was reclined back and would be unable to reach the foot lever, as it is located behind the recliner.</p> <p>An additional surveyor observation of the video footage from 4/24/2024 at 9:51 PM, revealed that NA, Staff D was observed pushing the resident out of the room in his/her recliner chair. At 9:58 PM Staff D pushes Resident ID #2 back into the dayroom, in a wheelchair. Resident ID #2 is holding his/her chest area as s/he reenters the room and Staff D places the resident with his/her back against the wall. Staff D aggressively grabs both of Resident ID #2's arms and holds them up so that CMT, Staff E can push a table against Resident ID #2's chest. At this time, Staff D was noted to push the table again, causing the table to be wedged between the resident and a support column. Staff D then pulled Resident ID #7's recliner, towards Resident ID #2's wheelchair, so the footrest of Resident ID #7's recliner was propped up on Resident ID #2's wheelchair, preventing the recliner from returning to an upright position, not allowing Resident ID #7 to get up independently.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a surveyor interview on 5/2/2024 at 12:37 PM, with the Administrator and the Director of Nursing Services (DNS), they acknowledged that Resident ID #2 was being physically restrained on 4/24/2024, by Staff D and E. They acknowledged that s/he was unable to get up from the recliner chair. They further revealed that during the investigation of this incident, numerous staff have revealed that Resident ID #2 and #7 are often restrained in this manner, due to the residents being at risk for falls. They indicated that Licensed Practical Nurse, Staff A, told administration that she did, at times, have Nursing Assistants restrain residents in the day room by placing the resident in a recliner sideways against the wall, with a table adjacent to the resident on the other side, a chair at the foot of the recliner, as well as another resident behind them.</p> <p>Review of the facility assessment, last revised 1/19/2024 revealed the facility provides education on physical restraints.</p> <p>Review of a document titled, 2023 Mandatory Annual Training Quarterly Crosswalk revealed an education topic titled Restraint and Seclusion, to be completed by staff in quarter 4 of 2023.</p> <p>Record review failed to reveal evidence that the following staff completed the mandatory restraint and seclusion education in 2023:</p> <ul style="list-style-type: none"> - NA, Staff D, hired on 9/22/2009 - CMT, Staff E, hired on 8/18/2009 - NA, Staff G, hired on 6/12/2022 - NA, Staff H, hired on 10/6/2016 - NA, Staff I, hired on 6/10/2016 <p>During a surveyor interview on 5/6/2024 at 2:03 PM, with the Regional Nurse, in the presence of the Administrator and the DNS, they were unable to provide evidence that the restraint and seclusion training was completed for the above-mentioned staff.</p> <p>Cross reference F 604</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>21613</p> <p>Based on record review and staff interview, it has been determined the pharmacist failed to report irregularities to the attending physician, the facility's Medical Director, and the Director of Nursing Services (DNS) for 1 of 3 residents reviewed for monthly drug regimen reviews, Resident ID #8.</p> <p>Findings are as follows:</p> <p>Record review revealed the resident was admitted to the facility in January of 2021 with diagnoses including, but not limited to, dementia, anxiety, and depression disorder.</p> <p>Record review revealed the resident has a physician's order dated 12/1/2023 for Lorazepam (a medication used to treat anxiety disorders or for serious seizures that do not stop) Oral Concentrate 2 milligrams (MG)/milliliter (ML), with instructions to give 1 ML by mouth every 24 hours as needed for a seizure lasting more than 5 minutes. Further review of the order failed to reveal evidence of an end date or a documented rationale for extending the duration of use for this as needed medication.</p> <p>Record review of the May 2024 Medication Administration Record revealed that the resident received the above-mentioned medication one time at 1:53 PM on 5/1/2024 and was noted to have a good effect.</p> <p>Review of the Pharmacist Consultation Recommendation Reports for the following dates failed to reveal evidence that the pharmacist identified that the above order did not have an end date:</p> <ul style="list-style-type: none"> - 12/13/2023 - 1/8/2024 - 2/5/2024 - 3/5/2024 - 4/28/2024 <p>During a surveyor interview with the Pharmacist on 5/7/2024 at 9:45 AM, he revealed that he completed the consultation reports for 3/5/2024 and 4/28/2024. The Pharmacist was unable to provide evidence that the above irregularity was reported to the attending physician, the facility's Medical Director, and the DNS as required.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>21613</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure a resident's drug regimen is free from unnecessary psychotropic drugs who have as needed psychotropic medication orders extending beyond 14 days, for 1 of 3 residents reviewed for unnecessary medication, Resident ID #8.</p> <p>Findings are as follows:</p> <p>Record review revealed the resident was admitted to the facility in January of 2021 with diagnoses including, but not limited to, dementia, anxiety and depression disorder.</p> <p>Record review revealed the resident has a physician's order dated 12/1/2023 for Lorazepam (a medication used to treat anxiety disorders or for serious seizures that do not stop) Oral Concentrate 2 milligrams (MG)/milliliter (ML), with instructions to give 1 ML by mouth every 24 hours as needed for a seizure lasting more than 5 minutes. Further review of the order failed to reveal evidence of an end date or a documented rationale for extending the duration of use for this as needed medication.</p> <p>Record review of the May 2024 Administration Record revealed that the resident received the above-mentioned medication one time at 1:53 PM on 5/1/2024, and it was noted to have a good effect.</p> <p>During a surveyor interview with Licensed Practical Nurse, Staff F, on 5/6/2024 at 1:25 PM, she revealed that the resident does not have a diagnosis of a seizure disorder and/or any history of seizure activity. Staff F further revealed that she administered the medication to the resident on 5/1/2024 because the resident was scratching his/her arms.</p> <p>During a surveyor interview with the Director of Nursing Services on 5/6/2024 at 1:30 PM, she acknowledged that the above order has no end date and that the resident received the medication for a purpose it was not ordered for.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>21613</p> <p>Based on record review and staff interview it has been determined that the facility's Quality Assessment and Assurance Improvement (QAPI) committee failed to develop and implement appropriate plans of action to correct the identified quality deficiencies relative to resident abuse and resident rights.</p> <p>Findings are as follows:</p> <p>Record review revealed the facility received a pattern of deficiencies relative to resident abuse and resident rights on the following dates:</p> <p>- 1/24/2024: F 600 for the failure to protect a resident from abuse by a staff member (a housekeeper was observed kissing a resident) and F 609 for the failure to report an allegation of abuse in a timely manner, as required by state law.</p> <p>-2/19/2024 F 600 for the failure to protect a resident's right to be free from abuse by a staff member, relative to staff not providing incontinence care.</p> <p>Record review revealed that the facility provided education to only nursing staff relative to resident abuse and resident rights on 3/4/2024 and audited incontinence care.</p> <p>Further record review failed to reveal evidence that the facility had developed a plan to include monitoring and evaluation of performance indicators, including the methodology and frequency for such development and monitoring, and evaluating the plan to determine if they are sustaining corrections, or if revision is necessary.</p> <p>Review of a facility reported incident submitted to the Rhode Island Department of Health on 4/26/2024 revealed that Nursing Assistant (NA), Staff B, reported an allegation of abuse that occurred on 4/24/2024 between Resident ID #2 and two staff members, NA, Staff D and Certified Medication Technician (CMT), Staff E. Staff B indicated that she overheard a resident yelling out loudly followed by a bang noise around 9:30 PM.</p> <p>Additionally, review of a facility reported incident submitted to the Rhode Island Department of Health on 5/2/2024 revealed an allegation of abuse that occurred on 4/24/2024 during the second shift (3:00 PM-11:00 PM), before dinner, involving Resident ID #1, Staff D and Staff E. The resident was overheard screaming help me, don't hit me, stop hitting me, you're not my mom.</p> <p>Record review failed to reveal evidence that the allegation involving Resident ID #1 was acted upon immediately. This failure allowed the NA, Staff D and CMT, E to continue working on the evening of 4/24/2024.</p> <p>(continued on next page)</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a surveyor interview with the Administrator and the Director of Nursing Services (DNS) on 5/2/2024 at 12:37 PM, they revealed that since they learned about the two allegations of abuse that had occurred on 4/24/2024, they have provided education relative to abuse and restraints to nursing staff only. The Administrator and the DNS were unable to provide evidence that the facility has developed a QAPI plan to include monitoring and evaluation of performance indicators, including the methodology and frequency for such development and monitoring, and evaluating the plan to determine if they are sustaining corrections, or if revision is necessary.</p> <p>During the survey, findings which constituted Immediate Jeopardies were identified as the facility failed to keep residents free from physical abuse, failed to keep residents free from physical restraints, and failed to report an allegation of abuse to the Administrator or his or her designated representative, investigate an allegation of abuse, and implement a plan to prevent further incidents of abuse from occurring.</p> <p>Cross reference F 550, F 600, F 604 and F 610.</p>		

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<p>F 0941</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members.</p> <p>21613</p> <p>46241</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that all direct care staff completed mandatory effective communication training, for 5 out of 7 staff reviewed, Staff D, E, G, H, and I.</p> <p>Findings are as follows:</p> <p>Record review failed to reveal evidence that the following staff completed the mandatory effective communication training or education for 2023:</p> <ul style="list-style-type: none"> - NA, Staff D, hired on 9/22/2009 - Certified Medication Technician, Staff E, hired on 8/18/2009 - NA, Staff G, hired on 6/12/2022 - NA, Staff H, hired on 10/6/2016 - NA, Staff I, hired on 6/10/2016 <p>During a surveyor interview on 5/6/2024 at 2:03 PM, with the Regional Nurse, in the presence of the Administrator and Director of Nursing Services, they were unable to provide evidence that the training was completed for the above-mentioned staff.</p>

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<p>F 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program.</p> <p>21613</p> <p>46241</p> <p>Based on record review and staff interview, it has been determined that the facility failed to provide mandatory training to all their staff, that outlines and informs staff of the elements and goals of the facility's QAPI (Quality Assurance and Performance Improvement) program, for 5 out of 7 staff reviewed, Staff D, E, G, H, and I.</p> <p>Findings are as follows:</p> <p>Record review failed to reveal evidence that the following staff completed QAPI training or education for 2023:</p> <ul style="list-style-type: none"> - NA, Staff D, hired on 9/22/2009 - Certified Medication Technician, Staff E, hired on 8/18/2009 - NA, Staff G, hired on 6/12/2022 - NA, Staff H, hired on 10/6/2016 - NA, Staff I, hired on 6/10/2016 <p>During a surveyor interview on 5/6/2024 at 2:03 PM, with the Regional Nurse, in the presence of the Administrator and Director of Nursing Services, they were unable to provide evidence that the training was completed for the above-mentioned staff.</p>		

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<p>F 0946</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide training in compliance and ethics.</p> <p>21613</p> <p>46241</p> <p>Based on record review and staff interview, it has been determined that the facility failed to provide mandatory training to all their staff, that outlines compliance and ethics, including an effective way to communicate the program's standards, policies, and procedures, for 5 out of 7 staff reviewed, Staff D, E, G, H, and I.</p> <p>Findings are as follows:</p> <p>Record review failed to reveal evidence that the following staff completed training or education on compliance and ethics for 2023:</p> <ul style="list-style-type: none"> - NA, Staff D, hired on 9/22/2009 - Certified Medication Technician, Staff E, hired on 8/18/2009 - NA, Staff G, hired on 6/12/2022 - NA, Staff H, hired on 10/6/2016 - NA, Staff I, hired on 6/10/2016 <p>During a surveyor interview on 5/6/2024 at 2:03 PM, with the Regional Nurse, in the presence of the Administrator and Director of Nursing Services, they were unable to provide evidence that the training was completed for the above-mentioned staff.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415087	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2024
NAME OF PROVIDER OR SUPPLIER Greenville Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 735 Putnam Pike Greenville, RI 02828	

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 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide behavior health training consistent with the requirements and as determined by a facility assessment.</p> <p>21613</p> <p>46241</p> <p>Based on record review and staff interview, it has been determined that the facility failed to provide all staff with behavioral health training, for 5 out of 7 staff reviewed, Staff D, E, G, H, and I.</p> <p>Findings are as follows:</p> <p>Record review failed to reveal evidence that the following staff completed the mandatory behavioral health training or education for 2023:</p> <ul style="list-style-type: none"> - NA, Staff D, hired on 9/22/2009 - Certified Medication Technician, Staff E, hired on 8/18/2009 - NA, Staff G, hired on 6/12/2022 - NA, Staff H, hired on 10/6/2016 - NA, Staff I, hired on 6/10/2016 <p>During a surveyor interview on 5/6/2024 at 2:03 PM, with the Regional Nurse, in the presence of the Administrator and Director of Nursing Services, they were unable to provide evidence that the training was completed for the above-mentioned staff.</p>