STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415091	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steere House Nursing and Rehabilitation Ctr	100 Borden Street Providence, RI 02903

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47279 Based on surveyor observation, record review, and staff interview it has been determined that the facility failed to protect and keep residents free from physical abuse relative to an incident that occurred between Resident ID #2 and #3, resulting in significant injury of Resident ID #2. Findings are as follows: Review of a facility policy titled, Abuse prohibition states in part, .It is the policy of this facility to ensure that all residents are treated with respect and dignity and that all residents are free from abuse .Abuse: Willful infliction of injury .resulting in physical harm .Examples of abuse include but are not limited to the following: Physical - Hitting, punching, pinching, kicking . Record review reveals a facility reported incident of resident-to-resident abuse was submitted to the Rhode Island Department of Health on 5/17/2024. The report indicates that Resident ID #2 reported to staff that Resident ID #3 had kicked him/her when s/he was exiting the bathroom. Additionally, Resident ID #2 sustained a skin tear to his/her left leg. Review of the 5-Day Investigation Report dated 5/22/2024, revealed that after the facility's investigation, the allegation of resident-to-resident abuse was substantiated as Resident ID #3 admitted to hitting Resident ID #2 with a trash can. Record review revealed Resident ID #2, the victim, was admitted to the facility in August of 2023 with diagnoses including, but not limited to, adjustment disorder with anxiety and disorders of the brain due to a temporal mass (mass on the temporal lobe of the brain that may affect essential functions including comprehension, emotions, and memory). Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 9 out of 15 indicating moderately impaired cognition. Review of a progress note dated 5/17/2024 at 1:30 PM authored by Registered Nurse, Staff A, revealed that Resident ID #2 approached the nurses' station with his/her pant leg rolled up exposing an open area that was not there prior. The progress note further revealed that Resident ID #2 indicated that when s/he was exiting the bathroom, the roommate kicked him/her. Additionally, the open area on Resident ID #2's left shin required it to be cleansed and dressed with wound treatment supplies. (continued on next page)

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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a document titled, Event Report dated 5/17/2024 revealed Resident ID #2 sustained a 1.7 centimeter (cm) by 1.4 cm open area to his/her left shin requiring a normal saline cleanse, the application of steri-strips (thin adhesive bandages used to close cuts or wounds), the application of xeroform (sterile wound dressing), and coverage with a clean dry dressing. Further review of the above-mentioned document revealed that Resident ID #2's wound was treated from 5/17/2024 through 6/16/2024, a duration of 31 days. Record review revealed Resident ID #3, the perpetrator, was admitted to the facility in July of 2022 with a diagnosis including, but not limited to, left lower arm fracture. Review of a quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 out of 15 indicating intact cognition. Review of a progress note dated 5/17/2024 at 6:36 PM revealed that Resident ID #3 was in agreement to move to a different room due to the altercation with his/her roommate, Resident ID #2. Record review revealed that Resident ID #3 has had 7 room changes since his/her admission in July of 2022. During a surveyor interview on 7/30/2024 at 1:34 PM with Staff A, she revealed that Resident ID #3 has been moved several times in the past as s/he can be a difficult roommate. She further revealed that Resident ID #2 sustained a wound to his/her left shin and was followed by the provider for his/her left shin wound and required daily dressing changes for approximately 1 month. During a surveyor observation on 7/30/2024 at 1:38 PM of Resident ID #2 in the presence of Staff A, revealed a noticeable discolored scar and indentation to his/her left shin. During a surveyor interview on 7/30/2024 at 1:41 PM with Resident ID #3, s/he revealed that s/he recalled the altercation with Resident ID #2 and indicated that s/he grabbed a trash can and hit Resident ID #2 in the leg with it. Additionally, s/he acknowledged that it was a deliberate act. During a surveyor interview on 7/30/2024 at 2:28 PM with the Director of Nursing Services in the presence of the Administrator, she was unable to provide evidence that Resident ID #2 was kept free from physical abuse.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47279 Based on record review and staff interview, it has been determined that the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 3 residents reviewed for a urinary tract infection (UTI), Resident ID #1. Findings are as follows: Record review revealed that the resident was admitted to the facility in March of 2022 with diagnoses including, but not limited to, mild cognitive impairment and history of falling. Review of a progress note dated 7/27/2024 at 12:03 AM revealed that the resident returned from the hospital following a fall and was diagnosed with a UTI. Additionally, s/he was started on Cephalexin (an antibiotic) 500 milligrams (mg) every 12 hours for 7 days. Review of a physician's order dated 7/27/2024 revealed Cephalexin 500mg give 1 tablet every 12 hours with an end date of 8/2/2024. Record review failed to reveal evidence that a care plan was developed and implemented for the UTI that the resident is currently being treated for. During a surveyor interview on 7/30/2024 at 10:43 AM with Minimum Data Set Coordinator, Staff D, she acknowledged that the resident's comprehensive care plan was not developed to include a UTI. She revealed that it should have been updated right away to include a UTI. During a surveyor interview on 7/30/2024 at 10:50 AM with Director of Nursing Services, she revealed that she would expect that the resident's comprehensive care plan would have been developed to include a focus area for a UTI. Cross reference F 689

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47279 Based on record review and staff interview it has been determined that the facility failed to ensure that residents receive adequate supervision to prevent an accident for 1 of 3 residents reviewed for elopement, Resident ID #1. Findings are as follows: Review of a facility policy titled, Identification of High Risk Elopement Residents states in part, Purpose: To ensure the safety and well being of all residents with a potential for wandering/eloping from the facility . Residents who were not identified to be 'at risk for elopement' on admission, but are demonstrating behaviors such as .accessing the elevator or exit doors are considered to be 'at risk for elopement.' Review of a community reported complaint allegation submitted to the Rhode Island Department of Health on 7/26/2024 revealed that Resident ID #1 was evaluated at the emergency room following a fall from his/her wheelchair. Additionally, Resident ID #1 had wheeled him/herself out the front door of the facility, the wheelchair began to roll downhill, and Resident ID #1 fell out of his/her wheelchair to avoid oncoming traffic. Record review revealed that the resident was admitted to the facility in March of 2022 with diagnoses including, but not limited to, mild cognitive impairment and a history of falling. Additionally, the resident resides on the second floor and has unrestricted access to the second-floor lobby where the main elevator is located, which leads to the main entrance located on the first floor. Review of a quarterly Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status score of 4 out of 15 indicating severe cognitive impairment. Further review revealed that the resident utilizes a wheelchair for mobility and can independently wheel a minimum of 150 feet in a corridor or similar space. Record review revealed the following progress notes: - 7/26/2024 at 3:48 PM revealed that the resident was found outside of the facility lying on the ground with a bump to his/her forehead with active bleeding and skin tears to his/her left arm, and was extremely confused. Additionally, Nursing Assistant (NA), Staff B, witnessed the resident wheel him/herself out of the facility and the resident was engaging in conversation with another person when his/her wheelchair began to roll. Staff B chased after the resident and witnessed him/her fall from his/her wheelchair onto the ground. Further, Emergency Medical Services was contacted and s/he was transported to the hospital. - 7/26/2024 at 5:17 PM revealed that the resident was administered medication to lower his/her blood pressure in the emergency room as his/her blood pressure was elevated at 210/94 (normal blood pressure is 120/80). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- 7/27/2024 at 12:03 AM revealed that the resident returned from the hospital and was noted with a skin tear to his/her head and left arm, a hematoma (abnormal pooling of blood under the skin that can be caused from injury or trauma) to his/her left forehead, and facial bruising. Additionally, the skin tears required treatments that consisted of a normal saline cleanse, the application of steri-strips (thin adhesive bandages used to close cuts or wounds), the application of xeroform (sterile wound dressing), and coverage with a clean dry dressing. Further, the resident was diagnosed with a urinary tract infection and was started on a 7-day course of antibiotic therapy. - 7/29/2024 at 1:35 PM revealed that the resident indicated the above-mentioned injury was still causing him/her discomfort. Review of the July 2024 Medication Administration Record (MAR) revealed that the resident had been receiving Tylenol (medication to treat pain) 1 gram (g) twice daily. Additionally, s/he had an as needed order for Tylenol 1g once a day which had not been utilized prior to the incident that occurred on 7/26/2024. Further review of the MAR revealed the resident received Tylenol on 7/28 and again on 7/30/2024 for complaints of pain. Review of a document titled, Elopement Risk Evaluation dated 6/19/2024, authored by Registered Nurse, Staff C, revealed that the resident was not deemed an elopement risk, however required Supervision - oversight, encouragement or cueing for locomotion off of the unit (how the resident moves to and returns from off-unit locations). Further, the document indicated to refer to the Activities of Daily Living (ADL) flow chart in the Resident Assessment Instrument (RAI) Manual to facilitate accurate coding. Review of the RAI Manual, Version 3.0 dated October 2023, states in part, .Supervision or touching assistance .For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete the activity . During a surveyor interview on 7/30/2024 at 12:50 PM with Staff C, she acknowledged she was the nurse that completed the Elopement Risk Evaluation. She further revealed that she did not utilize the RAI manual to accurately code the Elopement Risk Evaluation, however the resident is with staff while off the unit and that is why she indicated on the assessment that the resident requires supervision while off the unit. Additionally, she revealed that when the resident is off the unit, s/he is under general supervision by staff and provided the examples of when the resident is participating in activities or watching a movie. During a surveyor interview on 7/30/2024 at 10:24 AM with Staff B, she revealed that she was outside the facility by the main entrance on her break when she observed the resident wheel him/herself out of the front doors. Staff B indicated that no staff was present with the resident. Staff B further revealed that she was on her cell phone and looked up and saw the resident engaged in conversation with a visitor, then resumed looking at her cell phone. Staff B indicated that she heard the resident scream and looked up from her cell phone to see that the resident was rolling down the parking lot and she began to chase him/her but was unable to catch him/her before s/he fell from his/her wheelchair. Further, Staff B indicated to the surveyor the location of where the resident fell , which was at the exit of the parking lot where the parking lot adjoins the street. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a surveyor interview on 7/30/2024 at 1:12 PM with the Director of Nursing Services, she revealed that the resident should be in generally supervised areas. She was unable to explain how the resident was able to exit his/her unit, take the elevator to the 1st floor main lobby, and exit the building without staff properly supervising the resident while off the unit. She was unable to provide evidence that the resident received adequate supervision to prevent an accident.