

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2024
NAME OF PROVIDER OR SUPPLIER Crystal Lake Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 999 South Main Street Pascoag, RI 02859	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48928</p> <p>Based on record review, staff and resident interview, it has been determined that the facility failed to provide reasonable accommodation of resident needs and preferences, relative to individualizing the physical environment relative to the resident's bedroom and bathroom [ROOM NUMBER] of 1 resident reviewed, Resident ID # 1, who is visually impaired.</p> <p>Findings are as follows:</p> <p>Record review of a community reported complaint submitted to the Rhode Island Department of Health on 2/22/2024, alleges that a resident was moved from his/her room while s/he was out of the facility. His/her room was moved without notification to the resident or the resident's representative. Additionally, the resident, who is legally blind, was moved out of a private room with a bathroom that s/he had resided in for several years, to a semiprivate room without a bathroom.</p> <p>Record review revealed that the resident was admitted to the facility in March of 2017 with diagnoses including, but not limited to major depressive disorder, visual hallucinations, low vision right eye, and blindness in the left eye.</p> <p>Record review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating s/he is cognitively intact. Additionally, the assessment revealed that s/he is independent with self-care including dressing and toileting tasks.</p> <p>During a surveyor interview with the resident on 2/26/2024 at 12:20 PM, s/he revealed that s/he was approached by the Administrator in the weeks previous requesting that s/he change rooms, as the Administrator wanted to make his/her private room an isolation room. The resident refused as s/he explained to the Administrator that s/he is legally blind and had been in his/her current room for 5 years. S/he indicated to the Administrator that s/he was familiar with the layout of the environment and it would be difficult to acclimate to a new room as s/he can't see. The resident further revealed during a brief hospital stay on 2/19/2024 s/he returned to the facility on [DATE] to find his/her belongings from his/her private room were packed into boxes and moved into a semi private room without his/her permission. Additionally, s/he revealed that while in the new room s/he tripped over his/her belonging that were packed into boxes and placed near his/her bed as s/he couldn't see them and was unfamiliar with the new environment that s/he has been involuntarily moved into.</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 0558</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a progress note dated 2/19/2024 revealed the resident was sent to the emergency roianom on [DATE] by the facility Ophthalmologist, as the resident had increased pressure in his/her eyes. The resident was admitted and returned to the facility on [DATE] at 5:00 PM into a semi private room.</p> <p>Further record review revealed a progress note dated 2/21/2024 at 8:31 PM indicating that as soon as the resident returned from the hospital s/he was very upset that his/her room had been changed. S/he proceeded into his/her previous room, banging his/her fists on the walls and glass windows of the dining room. The resident began crying and making statements about harming him/herself and others. S/he stated its going to be a massacre.</p> <p>Further record review revealed the resident was inconsolable by the staff and had to be sent to the emergency room for his/her behaviors. The resident was admitted to hospital geri-psych unit on 2/21/2024.</p> <p>Further record review failed to reveal a past psych history.</p> <p>Record review of the hospital paperwork from the geri psych dated 2/21/2024 revealed that the resident was upset about his/her room change that occurred at the nursing home and denied any suicidal or homicidal ideations. The paperwork also states that they called the facility and spoke to the Administrator and she indicated that private rooms are for isolation and the resident can return into a semi private room.</p> <p>Record review revealed the Alliance for Better Long Term Care entered the facility on 2/23/2024 to speak to Resident ID #1 about the above complaint. Shortly after the Alliance exited the facility the resident was moved back to his/her original private room.</p> <p>During an interview with the Administrator on 2/27/2024 at 11:25 AM, she acknowledged that the resident's room was changed without his/her permission while at the hospital and the resident was moved into a room that s/he was unfamiliar with. The Administrator also acknowledged that she was aware that the resident tripped and sustained a fall over the boxes while in the semi private room. Additionally, she was unable to provide evidence that the facility provided reasonable accommodations of the residents needs and preferences relative to individualizing the physical environment relative to the resident's bedroom.</p> <p>Due to the facility failure of changing Resident ID #1's room without his/her permission and failing to individualize the physical environment relative to the resident's bedroom and bathroom due to his/her vision issues, caused this resident psychosocial harm as s/he had a behavioral outburst and was admitted to a geri-psych unit.</p> <p>Cross Reference: F 625 and F 684</p>		

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<p>F 0573</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48928</p> <p>Review of the State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities last revised 2/3/2023 states in part, The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays) .The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies .</p> <p>Review of a community reported complaint submitted to the Rhode Island Department of Health on 2/23/2024 alleges that the complainant requested in writing a copy of their spouse's medical records on or about August 11, 2023. The complainant was provided with what s/he believed to be an incomplete record. S/he was sent approximately 10 pages of his/her spouses's records. The report indicates that in September of 2023, additional attempts to obtain the missing records were made via telephone calls and written requests. There was no response by the facility to address the additional requests. Additionally, the report indicates the complainant was directed by the Administrator to contact facility contracted vendors, including the pharmacy for the remaining records.</p> <p>Record review revealed Resident ID #2 was admitted to the facility 3/1/2023 and discharged on [DATE].</p> <p>During a surveyor interview on 2/26/2024 at approximately 2:30 PM, with the Administrator, she acknowledged a complete record would contain physician notes, orders, care plans and therapy documentation at minimum, which would be greater than 10 pages.</p> <p>During this surveyor interview, the Administrator revealed she was aware of the request and had personally presented the file to the complainant. Additionally, she revealed she had instructed the complainant to contact the vendors for additional records.</p> <p>During a surveyor interview with the Administrator on 2/26/2024 at 2:55 PM, she acknowledged she did not present the complete medical record as requested.</p> <p>After being brought to the attention of the facility by the surveyor on 2/26/2024, a complete copy of the resident's medical file was printed, containing approximate 100 pages of records. The resident's representative was called by the Administrator to inform him/her that they could come pick up the records, this was approximately six months from the initial request.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>48928</p> <p>Based on record review and staff interview, it has been determined that the facility failed to provide written notice of the facility's bed-hold policy to the resident or resident representative, prior to the transfer of the resident to the hospital, for 1 of 1 resident reviewed, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Record review revealed the resident was admitted to the facility in March of 2017 with diagnoses including, but not limited to major depressive disorder, visual hallucinations, low vision right eye, and blindness in left eye.</p> <p>Record review revealed the resident was transferred from the facility to the hospital on 2/19/2024. Record review failed to reveal evidence of a written bed-hold policy that was provided to the resident or the resident's representative.</p> <p>During a surveyor interview on 2/27/2024 at 10:30 AM with the Administrator, in the presence of the Director of Nursing Services, she was unable to provide evidence of a written notice of the facility's bed-hold policy being given to the resident or resident's representative.</p> <p>Cross reference: F 558 and F 684</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48928</p> <p>Based on record review, staff and resident interview, it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 1 of 1 resident reviewed for falls, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Record review of a document titled Falls Management states in part .A fall risk evaluation will be conducted by the nurse on duty/supervisor on any resident/patient sustaining a fall with or without injury. Once the resident/patient is clinically evaluated as being stable, vital signs, neurological signs, range of motion, and evaluation of cognitive status will be documented .</p> <p>Record review revealed the resident was admitted to the facility in March of 2017 with diagnoses including, but not limited to major depressive disorder, visual hallucinations, low vision in the right eye and blindness in the left eye.</p> <p>Record review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating s/he is cognitively intact.</p> <p>During a surveyor interview with the resident on 2/26/2024 at 12:20 PM, s/he revealed that s/he was approached by the Administrator in the weeks previous requesting that s/he change rooms, as the Administrator wanted to make his/her private room an isolation room. The resident refused as s/he explained to the Administrator that s/he is legally blind and had been in his/her current room for 5 years. S/he indicated to the Administrator that s/he was familiar with the layout of the environment and it would difficult to acclimate to a new room as s/he can't see. The resident further revealed during a brief hospital stay on 2/19/2024 s/he returned to the facility on [DATE] to find his/her belonging from the private room were packed into boxes and moved into a semi private room without his/her permission. Additionally, s/he revealed that while in the new room s/he tripped over his/her belonging that were packed into the boxes and placed near his/her bed as s/he couldn't see them as s/he was unfamiliar with the new environment. The resident indicated to the surveyor that his/her knees were sore from the fall.</p> <p>Record review failed to reveal evidence that a post fall assessment was completed after the fall.</p> <p>During a surveyor interview on 2/27/2024 at 9:50 AM, with Licensed Practical Nurse, Staff A, she revealed that she was familiar with the resident and regularly cared for him/her. When the surveyor questioned Staff A about the fall she revealed that she was unaware that a fall had occurred.</p> <p>During a surveyor observation immediately following the above interview, Staff A, assessed the resident for injuries indicated to the surveyor that the resident's right knee appeared swollen and she would get the Medical Director as she was in the building. The Medical Director came to the room and assessed the resident and indicated that the resident did not appear to have a current injury.</p> <p>(continued on next page)</p>		

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