STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415099	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Lake Rehabilitation and Care Center	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46539 Based on record review, staff and resident interview, it has been determined that the facility failed to treat each resident with respect and dignity in an environment that promotes maintenance of his or her quality of life for 1 of 3 residents reviewed, Resident ID #1. Findings are as follows: Review of a community reported complaint submitted to the Rhode Island Department of Health on 2/28/2024 alleges that on 2/22/2024 Resident ID #1's mail was opened prior to him/her receiving it. The resident approached the Administrator about it and told her that it was an invasion of his/her privacy and she said that it was her right. The resident became very upset and she then made a comment that she was going to egg [him/her] on to get [him/her] out of here because this is not a psych ward. The Administrator continued to antagonize the resident and 911 was called. The police and rescue showed up and the responding officer told the Administrator that he was shocked that she was behaving this way towards a resident. He recorded the events on his body camera. Record review revealed the resident was admitted to the facility in July of 2023 with diagnoses including, but not limited to, parkinsonism and anxiety disorder. Review of a Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status score of 12 out of 15, indicating the resident has moderately impaired cognition. Record review revealed the following progress notes: - 1/24/2024 at 4:15 PM, authored by Licensed Practical Nurse, Staff A, revealed that the resident was angry that his/her mail was opened and after speaking with the Social Worker and the Administrator the resident demanded to call the police along with the Department of Health. Staff A was able to deescalate the resident. - 2/22/2024 at 11:58 AM, authored by the Social Worker, indicated that Resident ID #1's mail was accidentally opened and s/he was very upset about the situation. The Social Worker was informed that the resident banged his/her fist on the counter and showed outward aggression toward staff. The police were called to deescalate the situation. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview with the resident on 2/29/2024 at 8:42 AM, s/he revealed that on 2/22/2024, his/her mail was brought to him/her already opened and s/he was mad and felt very bad about it being opened. S/he further revealed that when s/he questioned the Administrator related to his/her mail being opened the Administrator called the police. During a surveyor interview on 2/29/2024 at 9:47 AM with Licensed Practical Nurse, Staff A, she revealed that the resident's mail was delivered by activities staff, and it was already opened. She revealed that this was not the first time it has happened. She revealed that the resident became upset, the Administrator called 911, and the resident called the police. Review of an incident report from the Burrillville Police Department dated 2/22/2024 stated in part, .Prior to speaking with [the resident], I activated my BWC [Body Worn Camera]. [The resident] advised that [s/he] was upset that staff opened [his/her] mail without permission. Units were able to calm [him/her] down, where [s/he] became very apologetic about [his/her] behavior .I stepped out of the room to speak with the Building Administrator .She was advised that [the resident] was upset about [his/her] mail being opened without [his/her] permission. However due to [him/her] being calm and mentally stable, rescue personnel could not force [him/her] into going to the hospital. [The Administrator] immediately stepped away from the conversation and entered the room. She began questioning [him/her] about [his/her] behavior, asking, ' .are you going to behave?' [the resident] became very agitated with [the Administrator's] tone and line of questioning. At that time medical personnel and I advised [the Administrator] she was the one escalating the situation and needed to step away. She snapped back, stating, 'No, I am not escalating.' I advised her she was not asking [him/her] but telling [him/her] instead .[The Administrator] was not sure who opened [the resident's] mail, but added it was their policy to check [his/her] mail prior to [him/her] getting it . During a surveyor interview on 2/29/2024 at 2:28 PM with the Administrator, she revealed that she doesn't remember saying that to the resident and she doesn't think she was escalating the resident. She further revealed that if that's what the police report says then she is not sure. Additionally, she was unable to provide evidence that this resident was treated with respect and dignity in an environment that promotes maintenance of his/her quality of life.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46539 Based on record review, staff, and resident interview it has been determined that the facility failed to respect the residents right to personal privacy for 1 of 2 residents reviewed who receive mail at the facility, Resident ID #1. Findings are as follows: Review of a facility policy titled, Residents Rights undated, states in part, .15. You have the right to send and receive mail promptly and unopened . Review of a community reported complaint submitted to the Rhode Island Department of Health on 2/28/2024 alleges that on 2/22/2024 Resident ID #1's mail was opened prior to him/her receiving it. The resident approached the Administrator about it and told her that it was an invasion of his/her privacy and she said that it was her right. The resident became very upset and she then made a comment that she was going to egg [him/her] on to get [him/her] out of here because this is not a psych ward. The Administrator continued to antagonize the resident and 911 was called. The police and rescue showed up and the responding officer told the Administrator that he was shocked that she was behaving this way towards a resident. He recorded the events on his body camera. Record review revealed that the resident was admitted to the facility in July of 2023 with diagnoses including, but not limited to, parkinsonism and anxiety disorder. Review of a Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status score of 12 out of 15, indicating the resident has moderately impaired cognition. Record review revealed the following progress notes: - 1/24/2024 at 4:15 PM, authored by Licensed Practical Nurse, Staff A, revealed that the resident was angry that his/her mail was opened and after speaking with the Social Worker and the Administrator the resident demanded to call the police along with the Department of Health. Staff A was able to deescalate the resident. - 2/22/2024 at 11:58 AM, authored by the Social Worker, indicated that Resident ID #1's mail was accidentally opened and s/he was very upset about the situation. The Social Worker was informed that the resident banged his/her fist on the counter and showed outward aggression toward staff. The police were called to deescalate the situation. During a surveyor interview with the resident on 2/29/2024 at 8:42 AM, s/he revealed that on 2/22/2024 his/her mail was brought to him/her already opened and s/he was mad and felt very bad about it being opened. S/he further revealed that when s/he questioned the Administrator related to his/her mail being opened, the Administrator called the police. (continued on next page)

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 2/29/2024 at 9:47 AM with Licensed Practical Nurse, Staff A, she revealed that the resident's mail was delivered by activities staff, and it was already opened. She revealed that this was not the first time it has happened. She revealed that the resident became upset, the Administrator called 911, and the resident called the police. During a surveyor interview with the Activity Aide, Staff B, on 2/29/2024 at 10:08 AM, she revealed that when she was passing the mail, the resident's mail was opened and that she knew that s/he was going to be mad. During a surveyor interview with the Administrator on 2/29/2024 at 10:20 AM, she revealed that she was called to the unit for the resident having an outburst. She revealed that she has opened the resident's mail in the past, but that she was unsure who opened it this time. Furthermore, she indicated that it was not her practice to open resident's mail. Review of an incident report from the Burrillville Police Department dated 2/22/2024 states in part, .[The Administrator] was not sure who opened [the resident's] mail, but added it was their policy to check [his/her] mail prior to [him/her] getting it . During a surveyor interview with the Administrator on 2/29/2024 at 2:28 PM, she was unable to provide evidence that the resident's right to personal privacy regarding his/her mail was respected.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46539 Based on record review, staff, and resident interview, it has been determined that the facility failed to ensure that resident's receive treatment and care in accordance with professional standards of practice, for 1 of 1 resident reviewed for an ordered dermatology consult, Resident ID #1. Findings are as follows: Record review revealed that the resident was admitted to the facility in July of 2023 with diagnoses including, but not limited to, parkinsonism, anxiety disorder and psoriasis vulgaris (chronic skin disease which results in scaly, often itchy areas in patches). Review of a Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status score of 12 out 15, indicating the resident has moderately impaired cognition. During a surveyor interview with the resident on 2/29/2024 at 8:42 AM, s/he revealed that s/he has been complaining about his/her skin for months and was told that s/he would be going to the dermatologist, however, s/he has not been yet. Further review of the record revealed the following: - 8/19/2023 at 2:15 PM, ADDED -To -Weekly Skin Check : Resident has scabs on top of left foot . Red , dry, scale on left sideburn and behind right ear. Resident told this writer It is a Psoriasis . It comes and goes . - 10/12/2023 at 11:40 AM, Dry Skin . - 11/17/2023 at 8:39 PM states in part, [the physician] in to see resident this evening. Resident [complaint] of dry lips, dry skin on [his/her] Hands .New orders per [the physician] as follow .Dermatology consult for hand eczema .Schedule Triamcinolone 0.5% BID [twice a day] for 7 days THEN BID PRN [as needed] . Record review of an emergency room Visit Note dated 1/17/2024 states in part, .Patient apparently called 911 on [his/her] own accord .[S/he] is alert and oriented for me as well as for EMS [emergency medical services]. [S/he] explained to EMS that [s/he] was not trying to call 911, rather [s/he] was trying to find somebody to talk about regarding being mistreated at [his/her] facility .[S/he] stated that [s/he] had a chronic rash .concerned that [s/he] has not had an appointment set up with dermatology for [his/her] chronic skin complaints . Record review revealed documentation dated 2/20/2024 at 11:12 AM which indicated, ADD-To-Body Check : .Both hands -dry and cracking -fingers along with both feet-toes-soles of the feet All dry areas washed, and dried well. Moisturizing lotion applied with resident's permission . During a surveyor interview on 2/29/2024 at 9:57 AM with Licensed Practical Nurse, Staff A, she revealed that the resident's hands are itchy and breaking down and was unsure if the resident went to the dermatologist. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 2/29/2024 at 10:28 AM with the resident's physician, Staff C, she revealed that she has spoken with the facility multiple times over the course of the resident's stay related to his/her skin and a need for a dermatology consult. She further revealed that she ordered one in November and is unsure as to why it has not been completed. Additionally, she revealed that the resident's skin is one of his/her biggest complaints and would have expected the resident to have been seen by a dermatologist as ordered. During a surveyor interview on 2/29/2024 at 11:47 AM with the Interim Director of Nursing Services, she revealed that the resident has not been seen by dermatology. Additionally, she was unable to provide evidence that the physician's order was followed related to a dermatology consult.

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46539 Based on record review and resident and staff interview, it has been determined that the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain the highest practicable physical, mental, and psychosocial well-being of each resident for 1 of 3 residents reviewed, Resident ID #1. Findings are as follows: Review of a community reported complaint submitted to the Rhode Island Department of Health on 2/28/2024 alleges that on 2/22/2024 Resident ID #1's mail was opened prior to him/her receiving it. The resident approached the Administrator about it and told her that it was an invasion of his/her privacy and she said that it was her right. The resident became very upset and she then made a comment that she was going to egg [him/her] on to get [him/her] out of here because this is not a psych ward. The Administrator continued to antagonize the resident and 911 was called. The police and rescue showed up and the responding officer told the Administrator that he was shocked that she was behaving this way towards a resident. He recorded the events on his body camera. Record review revealed the resident was admitted to the facility in July of 2023 with diagnoses including, but not limited to, parkinsonism and anxiety disorder. Review of a Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status score of 12 out of 15, indicating the resident has moderately impaired cognition. Record review revealed a progress note dated 2/22/2024 at 11:58 AM authored by the Social Worker which indicated that Resident ID #1's mail was accidentally opened, and s/he was very upset about the situation. The Social Worker was informed that the resident banged his/her fist on the counter and showed outward aggression toward staff. The police were called to deescalate the situation. During a surveyor interview with the resident on 2/29/2024 at 8:42 AM, s/he revealed that on 2/22/2024, his/her mail was brought to him/her already opened, s/he was mad and felt very bad about it being opened. S/he further revealed that when s/he questioned the Administrator related to his/her mail being opened, the Administrator called the police. During a surveyor interview on 2/29/2024 at 9:47 AM with Licensed Practical Nurse, Staff A, she revealed that the resident's mail was delivered by activities, and it was already opened. She revealed that this was not the first time it has happened. She revealed that the resident became upset, the Administrator called 911, and the resident called the police. (continued on next page)

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of an incident report from the Burrillville Police Department dated 2/22/2024 stated in part, .Prior to speaking with [the resident], I activated my BWC [Body Worn Camera]. [The resident] advised that [s/he] was upset that staff opened [his/her] mail without permission. Units were able to calm [him/her] down, where [s/he] became very apologetic about [his/her] behavior .I stepped out of the room to speak with the Building Administrator .She was advised that [the resident] was upset about [his/her] mail being opened without [his/her] permission. However due to [him/her] being calm and mentally stable, rescue personnel could not force [him/her] into going to the hospital. [The Administrator] immediately stepped away from the conversation and entered the room. She began questioning [him/her] about [his/her] behavior, asking, ' .are you going to behave?' [the resident] became very agitated with [the Administrator's] tone and line of questioning. At that time medical personnel and I advised [the Administrator] she was the one escalating the situation and needed to step away. She snapped back, stating, 'No, I am not escalating.' I advised her she was not asking [him/her] but telling [him/her] instead .[The Administrator] was not sure who opened [the resident's] mail, but added it was their policy to check [his/her] mail prior to [him/her] getting it . During a surveyor interview on 2/29/2024 at 10:20 AM and 2:28 PM with the Administrator, she revealed that she was called to the unit for the resident having an outburst. She revealed that she has opened the resident's mail in the past, but that she was unsure who opened it this time. Furthermore, she indicated that it was not her practice to open resident's mail. When presented with the initial complaint she revealed she did not feel as though she was antagonizing the resident. When notified of the police report statement, she revealed that she doesn't remember saying that to the resident, she doesn't think she was escalating the resident and did not remember stating, .it was their policy to check [his/her] mail prior to [him/her] getting it . When notified that the police officer involved was wearing a body camera, she further revealed that if that's what the police report says then she is not sure. Additionally, the Administrator was unable to provide evidence that the facility was being administrated in a manner to ensure the highest practicable physical, mental, and psychosocial well-being of each resident was maintained.