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	04/04/2024

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 - Some	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** 46118 Based on record review, staff, and resident representative interview, it has been determined that the facility failed to protect and promote the rights of the resident for 5 of 5 residents reviewed who had their picture posted on social media, Resident ID #s 5,6, 7, 8, and 9. Findings are as follows: Review of a community reported complaint submitted to the Rhode Island Department of Health of [DATE] alleges that Resident ID #6's photograph was posted to Facebook without the consent of the resident or of the resident's representative. 1. Record review revealed that Resident ID #6 was admitted to the facility in December of 2021 with diagnoses including, but not limited to, dementia and major depressive disorder. Further review revealed that the resident expired at the facility on [DATE]. Record review failed to reveal evidence that a consent for photographs to be taken or posted on a social media platform was signed by the resident or the resident's representative. Review of the facility's public social media Face Book page revealed that a photograph of the resident taken at the facility, to include his/her face, had been posted on [DATE]. Further review revealed the photograph was still online for the public to view on [DATE], approximately 2 ,d+[DATE] months after the resident expired. During a surveyor interview of [DATE] at 9:05 AM with the resident's family member, s/he indicated that the resident's photograph had been posted on the facility's social media Facebook page multiple times without the consent of the resident or of the resident's representative. S/he further indicated that it was upsetting to view the resident's photograph posted after his/her death. 2. Record review revealed that Resident ID #5 was originally admitted to the facility in February of 2021 with diagnoses including, but not limited to, dementia and Post Traumatic Stress Disorder (PTSD). Record review failed to reveal evidence that a consent for the photograph to be taken or posted on a social media platform was signed by the resident or the resident's representative. (continued on next page)

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's public social media Face Book page revealed that a photograph of the resident taken at the facility, to include his/her face, had been posted on [DATE]. Further review revealed the photograph was still available for the public to view on [DATE], indicating that the resident's photo had been posted for approximately, 39 days. 3. Record review revealed that Resident ID #7 was admitted to the facility in September of 2020 with a diagnosis including, but not limited to, cerebral infarction (stroke). Record review failed to reveal evidence that a consent for the photograph to be taken or posted on a social media platform was signed by the resident or the resident's representative. Review of the facility's public social media Face Book page revealed that a photograph of the resident taken at the facility, to include his/her face, had been posted on [DATE] and was still available for the public to view on [DATE]. 4. Record review revealed that Resident ID #8 was admitted to the facility in March of 2014 with diagnoses including, but not limited to, dementia and paranoid schizophrenia. Record review failed to reveal evidence that a consent for the photograph to be taken or posted on a social media platform was signed by the resident or the resident's representative. Review of the facility's public social media Face Book page revealed that a photograph of the resident taken at the facility, to include their face, had been posted on [DATE] and on [DATE]. Further review revealed the photographs were still available for the public to view on [DATE], indicating that the resident's photos had been posted for approximately, 86 days. 5. Record review revealed that Resident ID #9 was originally admitted to the facility in July of 2022 with diagnoses including, but not limited to, dementia and PTSD. Record review failed to reveal evidence that a consent for the photograph to be taken or posted on a social media platform was signed by the resident or the resident's representative. Review of the facility's public social media Face Book page revealed that a photograph of the resident taken at the facility, to include his/her face, had been posted on [DATE]. Further review revealed the photograph was still available for the public to view on [DATE], indicating that the resident's photo had been posted for approximately, 86 days. During a surveyor interview on [DATE] at 2:25 PM with the Activities Director, she indicated that the facility utilizes an outside company to post photos on the their Facebook page. She further indicated that she would expect a consent to be obtained from the resident or resident representative prior to a photograph to be taken and posted on the facility's social media page. Additionally, she could not provide evidence that any of the above-mentioned residents had a consent form signed in regards to publicly sharing photographs. During a surveyor interview on [DATE] at 3:10 PM with the Administrator, she indicated that she would expect that a consent form would be obtained from the resident or the resident's representative prior to any photographs to be taken and posted for public view. Additionally, she could not provide evidence that the facility protected and promoted the rights of the resident.

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 46118 Based on record review and staff interview, it has been determined that the facility failed to provide the necessary services to a resident who is unable to carry out activities of daily living (ADL) for 5 of 5 residents reviewed who are not independent with transfers and/or ambulation, Resident ID #s 1, 2, 3, 4, and 5. Findings are as follows: 1. Record review revealed that Resident ID #1 was readmitted to the facility in January of 2024 with diagnoses including, but not limited to, Wernicke's encephalopathy (a neurological disorder marked by mental confusion and unsteady gait- a person's manor of walking), cognitive communication deficit, and abnormalities of gait and mobility. Review of a care plan dated 1/2/2023 revealed the resident was at risk for falls with an intervention to assist the resident when standing or ambulating. Review of a Physical Therapy [PT] Discharge Summary dated 2/16/2024 revealed the resident required supervision with transfers and ambulation with his/her rolling walker. This document was requested by the surveyor as the PT Discharge Summary is not in Matrix (the electronic medical record). It is in a separate program that only therapy has access to. Record review failed to reveal evidence that the resident required supervision with transfers and ambulation with his/her rolling walker. Record review of the Nursing Assistant's (NA) assignment sheet failed to reveal the level of assistance the resident required for safety relative to transfers or ambulation. During a surveyor interview on 4/4/2024 at 11:07 AM with the Director of Rehab, she indicated that she would expect that a staff member would be visually supervising Resident ID #1 while transferring and ambulating. She further indicated that each resident is screened or evaluated upon admission to assess the level of assistance that is needed for transfers and ambulation. Additionally, she indicated that she verbally informs the nursing staff of the assistance each resident requires, as the nursing staff does not have access to the PT Discharge Summary as it is in a different program. 2. Record review revealed that Resident ID #2 was originally admitted to the facility in April of 2021 with diagnoses including, but not limited to, dementia and abnormalities of gait and mobility. Review of a care plan last revised 2/29/2024 revealed the resident was at risk for falls with an intervention to encourage the use of a gait belt (a device that is put around a resident's waist to assist with transfers or ambulation for safety). (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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Physical Therapy Discharge Summary dated 4/1/2024 revealed the resident required contact guard assistance (CGA- assistance of one hand to steady the resident) for transfers. This document was requested by the surveyor as the PT Discharge Summary is in not in Matrix (the electronic medical record). It is in a separate program that only therapy has access to. Record review failed to reveal evidence that the resident required CGA for transfers. Record review of the NA assignment sheet failed to reveal the level of assistance the resident required for safety relative to transfers or ambulation. During a surveyor interview on 4/4/2024 at 11:07 AM with the Director of Rehab, she indicated that Resident ID #2 required the assistance of one staff member for transfers. Additionally, she indicated that she verbally informs the nursing staff of the assistance each resident requires, as the nursing staff does not have access to the PT Discharge Summary as it is in a different program. 3. Record review revealed that Resident ID #3 was admitted to the facility in September of 2023 with diagnoses including, but not limited to, necrotizing fasciitis (a bacterial disease that causes death to soft tissue), and diabetes type two. Review of a care plan last revised 4/3/2024 revealed the resident was at risk for falls. Review of a PT Evaluation & [and] Plan of Treatment dated 3/18/2024 revealed the resident required MI [modified independence] for transfers and CGA for ambulation. This document was requested by the surveyor as the PT Discharge Summary is in not in Matrix (the electronic medical record). It is in a separate program that only therapy has access to. Record review failed to reveal evidence that the resident required CGA for ambulation. Record review of the NA assignment sheet failed to reveal the level of assistance the resident required for safety relative to transfers or ambulation. During a surveyor interview on 4/4/2024 at 11:07 AM with the Director of Rehab, she indicated that Resident ID #3 required staff supervision and the assistance of a walker for ambulation in the hallways. Additionally, she indicated that she verbally informs the nursing staff of the assistance each resident requires, as the nursing staff does not have access to the PT Discharge Summary as it is in a different program. 4. Record review revealed that Resident ID #4 was admitted to the facility in February of 2024 with diagnoses including, but not limited to, severe persistent asthma and necrosis of the bone (death of bone tissue). Review of a care plan last revised 3/14/2024 revealed the resident was at risk for falls. Review of a Physical Therapy Discharge Summary dated 3/25/2024 revealed the resident required a varied level of assistance from maximum assistance to stand by assistance with transfers. This document was requested by the surveyor as the PT Discharge Summary is in not in Matrix (the electronic medical record). It is in a separate program that only therapy has access to. (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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review failed to reveal evidence of any indication that the resident required maximum to stand by assistance for transfers. Record review of the NA assignment sheet failed to reveal the level of assistance the resident required for safety relative to transfers or ambulation. During a surveyor interview on 4/4/2024 at 11:07 AM with the Director of Rehab, she indicated that Resident ID #4 required a varied level of assistance ranging from the maximum assistance of two staff members to the supervision of staff for transfers. Additionally, she indicated that she verbally informs the nursing staff of the assistance each resident requires, as the nursing staff does not have access to the PT Discharge Summary as it is in a different program. 5. Record review revealed that Resident ID #5 was readmitted to the facility in December of 2021 with diagnoses including, but not limited to, hemiplegia and hemiparesis (loss of function on one side of the body) following a stroke and dementia. Review of a care plan last revised 1/3/2024 revealed the resident was at risk for falls related to dementia with an intervention to encourage the resident to request assistance with transfers. Review of a Physical Therapy Discharge Summary dated 12/22/2023 revealed the resident required minimal assistance of staff for transfers. This document was requested by the surveyor as the PT Discharge Summary is in not in Matrix (the electronic medical record). It is in a separate program that only therapy has access to. Record review failed to reveal evidence of any indication that the resident required minimal assistance for transfers. Record review of the NA assignment sheet failed to reveal the level of assistance the resident required for safety relative to transfers or ambulation. During a surveyor interview on 4/4/2024 at 11:07 AM with the Director of Rehab, she indicated that Resident ID #5 required minimal assistance for transfers. She further indicated that minimal assistance requires the assistance of one staff member for safety. Additionally, she indicated that she verbally informs the nursing staff of the assistance each resident requires, as the nursing staff does not have access to the PT Discharge Summary as it is in a different program. During a surveyor interview on 4/4/2024 at approximately 8:35 AM with Registered Nurse, Staff A, she acknowledged that the residents' transfer and ambulation status were not included in the record or on the NA assignment sheets. Additionally, she indicated that a verbal report is typically given to the NA's regarding the resident's transfer and ambulation status. During a surveyor interview on 4/4/2024 at approximately 8:45 AM with NA, Staff B, she indicated that the NA's are expected to ask nursing of the level of assistance needed for each resident. Additionally, she acknowledged that the resident's transfer status is not documented or accessible to the NA's who provide direct care for the residents. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 4/4/2024 at 11:24 AM with the Director of Nursing Services, she acknowledged that residents' transfer and ambulation status were not documented in the medical record or on the NA assignment sheets for the above mentioned residents. She further indicated that she would expect that the level of assistance required to safely transfer a resident should be documented in the resident's record and be readily accessible to direct care staff.

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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 - Immediate jeopardy to resident health or safety 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** 46118 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 elopement for 1 of 1 resident reviewed who successfully eloped, Resident ID #1. Findings are as follows: Record review of a facility reported incident submitted to the Rhode Island Department of Health on 3/29/2024 indicated that Resident ID #1 was found outside of the facility on 3/29/2024. Record review revealed that the resident was originally admitted to the facility in November of 2023 and was transferred to the hospital on 12/31/2023 for a change in mental status. S/he was readmitted to the facility in January of 2024 with diagnoses including, but not limited to, Wernicke's encephalopathy (a neurological disorder marked by mental confusion and unsteady gait), cognitive communication deficit, and abnormalities of gait (a person's manor of walking) and mobility. Review of the Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 4 out of 15, indicating s/he has severe cognitive impairment. Review of a care plan dated 1/2/2024 revealed the resident was at risk for elopement. Further review revealed a care plan dated 3/8/2024 which indicated that the resident exhibits behaviors of removing his/her wander guard (a device that is placed on a resident who is at risk for elopement to alert the facility that s/he has exited through an outside door). Once this resident exits through a door an alarm with sound. Review of a Physical Therapy Discharge Summary dated 2/16/2024 revealed the resident required supervision with transfers and ambulation with his/her rolling walker. Record review revealed a physician's order dated 3/6/2024 indicating that a wander guard should be worn on the resident's left ankle. Further review revealed the site and function of the wander guard was to be monitored every shift. Record review revealed the following progress notes indicating that the resident displayed exit seeking behaviors, wandering, and s/he also had a history of removing or hiding his/her wander guard: -1/6/2024 at 1:15 PM- the Nurse Practitioner was made aware of the resident's behaviors of continuously attempting to leave the facility and packing his/her clothing to leave -1/6/2024 at 5:56 PM- Wander guard placed on resident's right wrist and found broken on the floor a couple of hours later -1/7/2024 at 2:12 AM- resident very restless and confused, continuous redirection needed due to exit seeking behaviors (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-1/8/2024 at 7:56 AM- wander guard found in laundry on 1/6/2024, wander guard put on resident's right wrist then on 1/7/2024 and 1/8/2024 wander guard was unable to be located -1/9/2024 at 5:48 PM- resident attempting to get outside to get to his/her truck and had removed wander guard -1/19/2024 at 12:20 PM- resident stating that s/he needs to leave the facility and was seen packing his/her belongings -1/21/2024 at 4:36 PM- resident attempting to leave the facility with his/her belongings -1/25/2024 at 5:46 PM- resident redirected related to walking out of his/her room with a bag of belongings and searching for his/her truck -1/26/2024 at 9:43 AM- wander guard attached to wheelchair pole -1/29/2024 at 12:43 PM- wander guard removed from wheelchair and placed on resident's right ankle -2/2/2024 at 10:36 AM- wander guard found on the floor of resident's room and reapplied to his/her right ankle -2/2/2024 at 3:33 PM- wander guard found on the floor of resident's room and reapplied to his/her right ankle for the second time today -2/3/2024 at 2:46 PM- resident removed the wander guard off his/her ankle, wander guard placed on his/her right wrist -2/4/2024 at 3:25 PM- wander guard found in the trash can and applied to the resident's wheelchair -2/6/2024 at 2:26 PM- resident wandering up and down the hallways -2/13/2024 at 7:04 AM- unable to locate resident's wander guard -2/17/2024 at 10:00 AM- unable to locate resident's wander guard however, the bracelet was found in the trash can -2/20/2024 at 10:32 AM- Director of Nursing Services was made aware that the resident's wander guard could not be located -3/1/2024 at 3:31 PM- resident stating s/he wants to go home, waiting by the elevator and was able to enter the elevator which took staff 15 minutes to get him/her out, difficult to redirect -3/3/2024 at 2:50 PM- resident continues to remove wander guard -3/5/2024 at 10:12 AM- wander guard was broken on third shift; another one was put on and the resident removed it again (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-3/6/2024 at 12:26 AM- resident stating They left me behind. I need to go. wander guard not found on resident; another one was applied to his/her left ankle -3/6/2024 at 3:30 PM- resident removed wander guard from left ankle at 3:00 AM, another wander guard applied to his/her left ankle and education was provided. Record review of a progress note dated 3/9/2024 revealed the resident was found outside lying on the ground. Further review revealed the resident was sent to the hospital for an evaluation to rule out injury. Record review of the hospital emergency department document dated 3/9/2024 revealed that the resident was sent to the hospital following a fall at the facility resulting in a wound to his/her finger. Further record review revealed the resident was reported to be increasingly confused and had been stating that s/he wanted to go home while at the facility. Additionally, the resident was discharged back to the facility after his/her finger wound was dressed and all tests were found to be unremarkable. During a surveyor interview on 4/1/2024 at 11:40 AM with Licensed Practical Nurse (LPN), Staff C, she indicated that the resident exited the facility via the alarmed dining room doors on 3/9/2024 and was not wearing a wander guard, as ordered, at that time. She further indicated that no new interventions were put into place at that time to prevent the resident from going outside unsupervised. Record review failed to reveal evidence that any new interventions had been implemented to prevent an elopement following the resident being found outside with an injury to his/finger and after s/he had removed the wander guard on the above-mentioned dates. Further record review revealed the following: -3/10/2024 at 7:54 PM- resident does not have wander guard on, each time it was applied s/he removes it -3/12/2024 at 8:03 PM- wander guard applied to left ankle multiple times throughout the day and resident removing it and hiding it in his/her room -3/13/2024 at 7:06 PM- wander guard worn as a necklace, resident removed it -3/17/2024 at 4:18 PM- wandering up and down the hallways, wander guard is attached to wheelchair Record review revealed a progress note dated 3/29/2024 indicating that the resident was found outside in the front of the facility with his/her rolling walker. During a surveyor interview on 4/1/2024 at 2:08 PM with LPN, Staff C, she indicated that on 3/29/2024 the resident's wander guard was placed on his/her wheelchair and was not on his/her body or walker. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a surveyor interview on 4/1/2024 at 10:28 AM with the Director of Nursing Services (DNS), she indicated that the resident was found walking outside by a neighbor of the facility. She further indicated that the neighbor witnessed the resident fall and assisted him/her up. Additionally, she indicated that the resident was outside unsupervised when staff went outside to assist the resident back into the facility. During a surveyor interview on 4/1/2024 at 3:00 PM with the neighbor, who witnessed the elopement, s/he revealed that while walking on the street in the front of the facility s/he noticed the resident in the grass, by the street, at the end of the entrance to the facility. S/he further indicated that she witnessed the resident fall twice while attempting to ambulate outside by him/herself. Additionally, s/he indicated that s/he assisted the resident to the door of the facility where s/he left the resident alone with his/her walker. Furthermore, s/he indicated that s/he did not see any staff at that time. During a surveyor interview on 4/1/2024 at 12:23 PM with the DNS, she acknowledged that no new interventions had been put into place following the resident leaving the facility unsupervised on 3/9/2024 and that the resident was not wearing a wander guard as ordered on 3/29/2024 when s/he exited the building unsupervised for a second time. Additionally, she could not provide evidence that the facility ensured that the resident received adequate supervision to prevent an elopement. Due to the facility's failure to provide adequate supervision, this resident was able to exit the facility which put the resident at risk for more than minimal harm, impairment, or death.