STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The annual Federal Life Safety Code survey was conducted by the State Survey Agency. The facility was surveyed pursuant to the National Fire Protection Association 101 Life safety Code, 2012 Edition as referenced in 42 CFR 483.90 (a - d) - Physical Environment. Deficiencies were identified as a result of this survey.	K 000	The filing of this Plan of Correction (POC) does not constitute that the deficiencies alleged did in fact exist, rather this POC is filed as evidence of the facility's continuing commitment to high quality resident care in full compliance with state and federal regulations. Completion date for optimal compliance with the POC will be December 17, 2023	
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111)	K 161	12/7/23 RECEIVED DEC 06 2023 FACILITIES REGULATION	

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

NHA | Administrator | 12/6/23

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 161	Continued From page 1 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined that the facility is a two-story building with a wood frame construction Type V (000) which is not permitted over one story in height in accordance with Life Safety Code (LSC) Section 19.1.6.1, 19.1.6.2. through 19.1.6.7. This deficient practice could affect 31 of 31 residents, as well as an indeterminable number of staff and visitors. Findings are as follows: During a surveyor observation on 11/16/2023 at 1:00 PM with the Maintenance Director, revealed that the facility is a two-story building over a basement with a wood frame construction Type V (000). This construction type is not permitted for a healthcare occupancy over one story in height. During a surveyor interview on 11/16/2023 at 1:30 PM with the Administrator in the presence of the Maintenance Director, they acknowledged that	K 161	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	**60 EBEN BROWN LANE CENTRAL FALLS, RI 02863**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 161	Continued From page 2 the facility is a two-story building over a basement with a wood frame construction Type V (000) and that they are aware of this deficiency. Based on a passing Fire Safety Evaluation System completed on 11/16/2023, it has been determined that the citations are now in compliance with the LSC requirements.	K 161		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined that the facility failed to maintain the means of egress free of all obstructions for full use in case of emergency. This deficient practice could affect 31 of 31 residents as well as an indeterminable number of staff, and visitors. Findings are as follows: During a surveyor observation in the presence of the Maintenance Director on 11/16/2023 at 1:00 PM, revealed that a piece of exercise equipment, a wheelchair, and an electric fan, are being stored in the exit access from the sun porch of the first floor.	K 211	As a Plan of Correction (POC) for Life Safety Code Tag K 211 a) No residents were named in this finding. b) 31 of 31 residents and an indeterminable number of staff and visitors have the potential to be affected by this finding. c) We have moved the identified items (exercise equipment, a wheelchair and an electric fan) stored in the exit access in the first floor sun porch. Going forward we will prohibit storage in this area. We have provided education to the staff about not placing items in this area. Our Maintenance Director will monitor this area during rounds to ensure that the exit access from the first-floor sun porch is maintained free of obstruction. EM 12/7/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 3 During a surveyor interview with the Maintenance Director following the above observation, he acknowledged that the facility was storing equipment in the exit access from the sun porch of the first floor, and was unable to provide evidence that the means of egress was free from obstruction in case of emergency.	K 211	d) The administrator is responsible for implementing this plan. The rounds will be conducted on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 3 months; at which time, we will determine the need/ frequency to continue formal rounds.	
K 232 SS=F	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined that the facility failed to provide corridors that were at least 48 inches wide in accordance with the Life Safety Code (LSC) Section 19.2.3.4 and 19.2.3.5. This deficient practice could affect 31 of 31 residents, as well as an indeterminable number of staff and visitors. Findings are as follows: Record review of the National Fire Protection Association 101 2012 edition states in part... "19.2.3.4* Any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as means of egress from patient sleeping rooms..."	K 232	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 232	Continued From page 4 During a surveyor observation on 11/16/2023 at 1:00 PM, revealed that the first-floor exit access corridor, where the kitchen and 11 resident rooms are off of, has a width of approximately 41 inches. Further observations revealed that the second-floor corridor, where 6 resident rooms are off of, has a width of approximately 41 inches. During a surveyor interview on 11/16/2023 at 1:30 PM with the Administrator in the presence of the Maintenance Director, they acknowledged that the above-mentioned corridors are less than 48 inches in width. Based on a passing Fire Safety Evaluation System completed on 11/16/2023, it has been determined that the citations are now in compliance with the LSC requirements.	K 232		
K 252 SS=D	Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 This REQUIREMENT is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined that the facility	K 252	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	**60 EBEN BROWN LANE** **CENTRAL FALLS, RI 02863**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 252	Continued From page 5 failed to provide two approved exits from the corridors on the second floor in accordance with Life Safety Code Section 19.2.5.4, 7.4 and 7.5. This deficient practice could affect 6 out of 6 residents that resides on the second floor, as well as an indeterminable number of staff and visitors. Findings are as follows: Surveyor observation on 11/16/2023 at 1:00 PM failed to reveal evidence that two designated exits were located in the corridor. One designated exit was observed to be located in the nursing office. During a surveyor interview on 11/16/2023 at 1:30 PM with the Administrator in the presence of the Maintenance Director, they acknowledged that a designated exit for the second floor was located in the nursing office and not in the main corridor as required. Based on a passing Fire Safety Evaluation System completed on 11/16/2023, it has been determined that the citations are now in compliance with the LSC requirements.	K 252		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification Survey was conducted at Harris Health Care Center North from 11/14/2023 through 11/17/2023 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. A State licensure, emergency preparedness were also conducted at this facility. Deficiencies were cited as a result of this survey. Census: 31 Capacity: 32	F 000	The filing of this Plan of Correction (POC) does not constitute that the deficiencies alleged did in fact exist, rather this POC is filed as evidence of the facility's continuing commitment to high quality resident care in full	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's	F 655	compliance with state and federal regulations. Completion date for optimal compliance with the POC will be December 17, 2023 EM 12/1/23 As a Plan of Correction (POC) for Federal Tag F 655 a) Resident ID # 179 no longer resides in the facility. The baseline care plan was updated to include their medical condition. b) Residents who are new admissions have the potential to be affected by this finding. We have reviewed current baseline care plans and updated them appropriately if needed. RECEIVED DEC 06 2023 FACILITIES REGULATION	

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

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 1 admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to develop and implement a baseline care plan for each resident within 48 hours of a resident's admission, that includes the instructions needed to provide effective and person-centered care for the resident that meets professional standards of quality care relative to bilateral lower extremity edema (swelling caused due to excess fluid accumulation in the body tissues) for 1 of 2 new admissions, Resident ID #179. Finding are as follows: Record review revealed the resident was admitted to the facility in November of 2023 with diagnoses including, but not limited to, hypertension (high blood pressure) and atrial fibrillation (irregular heartbeat).	F 655	c) We have provided education to the nurses regarding the need to assess and identify medical conditions upon admission and to ensure that the base line care plan reflects these medical needs so that interventions are implemented. Each new admission is to be discussed during the morning clinical meeting to ensure that all needs are met. New admissions are to be reviewed during weekly risk meeting at which time their care baseline care plans are to be reviewed for completion and accuracy. We have established an audit tool to monitor our compliance with this plan.	

em 12/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 2 During a surveyor observation on 11/14/2023 at 9:25 AM, the resident was observed to have bilateral lower extremity edema. Review of the resident admission document tilted "Admission Observation" dated 11/10/2023 states in part "...left foot 2+ pitting edema (indentation that remains in the edematous area after pressure is applied)..." Record review of the baseline care plan initiated on 11/10/2023 failed to reveal evidence of a plan of care that includes interventions or treatments for bilateral lower extremity edema. During a surveyor observation and interview on 11/16/2023 at 2:14 PM with the Director of Nursing Services, she acknowledged that the resident has bilateral lower extremity edema and that a baseline care plan was not developed to address, monitor or treat the resident's edema. See F684	F 655	d) The DNS or designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 3 months; at which time, we will determine the need/ frequency to continue formal audits. EM 12/7/23	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684	As a Plan of Correction (POC) for Federal Tag F 684 a) Neither resident #28 nor resident #179 reside in the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 3 Based on record review, surveyor observation and staff interview it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan, for 1 of 3 residents reviewed for COVID-19, Resident ID #28, and 1 of 2 residents reviewed for new admissions, Resident ID #179. Findings are as follows: 1. Review of a facility policy titled "Care of the COVID-19 Positive Resident/Patient" last updated 11/2/2022 states in part, "...The residents care plan will be revised to reflect the infection status and care of the individual resident's needs..." Closed record review revealed that Resident ID #28 was readmitted to the facility in September of 2021 with diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD, lung disease) and type II diabetes mellitus. Review of a progress note dated 8/17/2023 states, "Resident at baseline, coughing more than usual. Positive covid at this shift. Plan of care modified, ongoing assessments." Review of a care plan dated 9/17/2021 revealed s/he has COPD with interventions including, but not limited to, monitor and document respiratory status. Further review of the care plan failed to reveal a care plan for COVID-19 infection status or care of the individual resident's needs. Record review failed to reveal evidence of an assessment of the resident's respiratory status. Further record review failed to reveal evidence of	F 684	b) Residents who have tested positive for COVID and those with lower extremity edema have the potential to be affected by this finding. We have reviewed these residents to ensure that COVID assessments and vital signs are being taken per protocol. We have reviewed those residents with lower extremity edema to ensure that medical treatment is in place per the physician and that nursing measures are being taken to reduce edema. We have made any corrections if necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 4 a complete set of vital signs obtained to include, blood pressure, pulse, oxygen saturation and respiratory rate. Review of a progress note dated 8/18/2023 revealed the resident was more lethargic than usual and refused to eat the breakfast meal. Additionally, it revealed that the resident expired on the same day. During a surveyor interview on 11/15/2023 at 11:54 AM with Registered Nurse (RN), Staff A, she revealed that the resident tested positive for COVID-19 on 8/17/2023. Additionally, she was unable to provide evidence of why an assessment or a complete set of vital signs was not obtained after the resident tested positive on 8/17/2023 and before s/he expired on 8/18/2023. During a surveyor interview on 11/15/2023 at 11:30 AM with the Director of Nursing Services (DNS) she acknowledged that a complete set of vital signs and an assessment was not completed for Resident ID #28 once s/he tested positive for COVID-19. Additionally, she revealed that she would expect that an assessment and a complete set of vital signs was obtained every shift. The DNS further acknowledged that there was not a care plan put in place for COVID-19. She was unable to provide evidence that residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan. 2. Record review revealed that Resident ID #179 was admitted to the facility in November of 2023 with diagnoses including, but not limited to, hypertension (high blood pressure) and atrial fibrillation (irregular heartbeat).	F 684	c) We have provided education to the nurses on the COVID protocol and stressed the importance of assessing the condition and obtaining vital signs on newly positive COVID residents. We have educated the nurses on the importance of complete and accurate assessment of newly admitted residents and the need to report positive findings to the physician and obtain and carry out medical orders as needed. Residents with changes in condition and new admissions are to be reviewed in clinical morning meeting and weekly risk meeting to ensure that appropriate care is being provided. We have devised an audit tool to monitor our progress compliance with this plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 5 Record review of an Admission Assessment dated 11/10/2023 revealed that s/he has left lower extremity edema (swelling caused due to excess fluid accumulation in the body tissues) graded at 2+ (indentation that remains in the edematous area after pressure is applied). The assessment failed to reveal evidence of edema to the right lower extremity. During a surveyor observation on 11/14/2023 at 9:25 AM the resident was noted to have bilateral lower extremity edema. Additionally, his/her legs were noted to not be elevated. Record review failed to reveal evidence of an assessment or care plan in place for the resident's edema. During a surveyor observation and interview on 11/15/2023 at 1:20 PM with Registered Nurse, Staff B, she acknowledged that the resident had bilateral lower extremity edema. Additionally, she revealed that the right lower extremity edema was approximately 3+ (moderate deep pitting, 6 mm indent for 30 seconds) and the left lower extremity was approximately 4+ edema (severe very deep pitting, 8 mm indent, greater than 30 seconds to return to normal). Staff B indicated she was going to report the increased edema to the Medical Director. During a surveyor observation on 11/16/2023 at 8:10 AM the resident was observed to have bilateral lower extremity edema and his/her legs were noted not to be elevated. Record review failed to reveal evidence of Staff B's assessment of the edema on 11/15/2023 and	F 684	d) The DNS/designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 3 months; at which time, we will determine the need / frequency to continue formal audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 6 failed to reveal evidence that the Medical Director was notified of the increased edema. During a surveyor interview on 11/16/2023 at 11:16 AM with the Medical Director he revealed that he was not notified regarding the resident's increased edema on 11/15/2023. Additionally, he revealed that he would have ordered the nurse to elevate the resident's legs and assess his/her respiratory status if he had been made aware. During a surveyor interview on 11/16/2023 at 2:14 PM with the DNS she acknowledged that the resident has increased bilateral lower extremity edema. Additionally, she acknowledged there was no evidence that the staff assessed the increased edema or reported the change to the physician. The DNS was unable to provide evidence that the residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan.	F 684		
F 699 SS=E	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to ensure that residents who are	F 699	As a Plan of Correction (POC) for Federal Tag 699 a) Resident ID # 12 and 21 reside in the facility and are receiving appropriate, trauma informed care. b) Residents with trauma histories have the potential to be affected by this finding. We are reviewing those residents to ensure that trauma informed care plans are in place and being implemented according to the trauma assessments. We have made any needed corrections.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 699	Continued From page 7 trauma survivors, receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents experiences, and preferences, in order to eliminate, or mitigate triggers that may cause re-traumatization of the resident for 2 of 5 residents reviewed for Trauma Informed Care, Resident ID #s 12 and 21. Findings are as follows: Review of the Centers for Medicare and Medicaid Services (CMS) State Operations Manual, Appendix PP Guidance to Surveyors for Long Term Care Facilities, last updated 2/3/2023 states in part, "...'Trauma' results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being... 'Trauma-informed care' is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization..." Review of the facility's form titled "PC [Primary Care]-PTSD [Post Traumatic Stress Disorder]-5" states in part, "...The primary PC-PTSD-5 is a 5-item screen designed to identify individuals with probable PTSD. Those screening positive require further assessment, preferably with a structured interview..."	F 699	c) We have reviewed the screening and assessment tool in current use and made any needed revisions. We have provided education to the facility social worker and social work designee on the importance of relating trauma informed care issues to the IDT so that trauma informed care plans can be developed and implemented. The clinical care staff has been educated on the importance of implementing trauma informed care plans. We have devised an audit to monitor our compliance with this plan. d) The DNS/designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI Committee for no less than 3 months; at which time, we will determine the need/ frequency to continue formal audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 699	Continued From page 8 1. Record review revealed Resident ID #12 was admitted to the facility in December of 2022, with diagnoses including, but not limited to, major depressive disorder and anxiety disorder. Review of the facility's form titled "PC-PTSD-5" dated 12/2/2022 indicates that the resident has "a trauma history-experiencing a traumatic event over the course of their life..." This form further indicates the following: -has nightmares about the event(s) or thought about the event(s) when s/he did not want to -tried hard not to think about the event or went out of his/her way to avoid situations that reminded him/her of the events -felt numb or detached from people, activities, or his/her surroundings Further record review failed to reveal a comprehensive assessment for trauma was completed. Additionally, review of a care plan dated 12/2/2022 revealed "Psychosocial well-being PTSD" with only one intervention "provide validation and support surrounding trauma Once A Day; 05:00 PM." During a surveyor interview with the Director of Nursing Services (DNS) on 11/17/2023 at 9:20 AM, she was unable to provide evidence that a comprehensive assessment for trauma was completed. Furthermore, she acknowledged that the above mentioned care plan was not individualized to include trauma informed care and interventions to eliminate, or mitigate triggers that may cause re-traumatization of the resident. 2. Record review revealed Resident ID #21 was	F 699		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 699	Continued From page 9	F 699		

admitted to the facility in May of 2009, with diagnoses including, but not limited to major depressive disorder, anxiety and depressed mood and schizophrenia (mental illness).

Review of the facility's form titled "PC-PTSD-5" dated 10/1/2022 indicates that the resident has "a trauma history-experiencing a traumatic event over the course of their life..."

Further record review failed to reveal a comprehensive assessment for trauma was completed.

Additional record review failed to reveal evidence of a trauma informed care plan with interventions to eliminate, or mitigate triggers that may cause re-traumatization of the resident.

During a surveyor observation and interview on 11/14/2023 at 11:28 AM, the resident was crying with his/her right hand shaking. During the interview, the resident revealed s/he is afraid that someone will hurt him/her. The resident further revealed s/he does not sleep well at night because s/he is afraid.

During an interview with the Admission Coordinator, who is the Social Worker Designee, on 11/15/2023 at 11:58 AM, she revealed that the facility's social worker informed her that there was "trauma in [the resident's] life" but she does not know the details of the trauma.

During a telephone interview with the facility's Social Worker on 11/16/2023 at 11:43 AM, she revealed the resident has a trauma history but she was unsure of the specific trauma or how it affects the resident. The Social Worker further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 699	Continued From page 10 revealed that the resident is very anxious and fearful, especially with authority (ex: police officers and immigration). Additionally, the Social Worker revealed she does not know who performs the comprehensive assesment for trauma or develops the trauma informed care plan. During a surveyor interview with the Minimum Data Set Assessment Coordinator on 11/16/2023 at 12:10 PM, she was unable to provide evidence of a trauma informed care plan with interventions to eliminate, or mitigate triggers that may cause re-traumatization of the resident. During a surveyor interview with on 11/17/2023 at 9:20 AM, with the DNS, she acknowledged that the comprehensive assessments for trauma were not completed and that the trauma informed care plans were not implemented for the above-mentioned residents.	F 699		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph	F 756	As a Plan of Correction (POC) for Federal Tag F 756 a) Residents ID # 24 has had the recommended laboratory testing as recommended and ordered by the physician. b) We have reviewed recent pharmacy recommendations and addressed any outstanding recommendations identified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 11 (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to ensure that the irregularities identified by the Clinical Consultant Pharmacist during the monthly pharmacist Medication Regimen Review (MRR) were acted upon for 1 of 5 residents reviewed, Resident ID #24. Findings are as follows: Record review for the resident revealed that s/he was admitted to the facility in July of 2023 with diagnoses including, but not limited to, fusion of spine (neurosurgical or orthopedic surgical	F 756	c) We have reviewed our method of addressing pharmacy recommendations and made any needed revisions to our system. The DNS or designee is to ensure that recommendations are acted on in a timely manner and completed as soon as possible. The nurses were provided with education on the importance of communicating the recommendation to the physician and transcribing and implementing any orders that result from the recommendations. An audit tool has been designed to monitor the outcome of this plan. d) The DNS/designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI committee for no less than 3 months; at which time we will determine the need/frequency to continue formal audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 12 technique that joins 2 or more vertebrae), type 2 diabetes mellitus, and hypertension (high blood pressure). Record review of the document titled "[Pharmacy] Consultation Report" revealed that on August 28, 2023, the following laboratory tests were recommended to be obtained for the resident: - Monitor A1C (glycohemoglobin - a test used to monitor how well a person's blood sugar level is being managed). - Monitor fasting lipid panel (a blood test that measures the amount of certain fat molecules called lipids in the blood). - Monitor serum creatinine (a blood test that measures how well your kidneys are performing their job of filtering waste from the blood). Further record review revealed that the physician accepted and authorized the above laboratory tests on September 6, 2023. Review of the resident's record failed to reveal evidence that the above-mentioned blood tests were obtained. Record review of the resident's pharmacy MRR for September 29, 2023, and October 30, 2023, revealed that the above stated laboratory tests were continued to be recommended but were not completed. During a surveyor interview with the Director of Nursing Services on 11/15/2023 at 11:14 AM, she was unable to provide evidence that the above-mentioned blood tests were completed	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 13 and acknowledged that it should have been completed as soon as the physician authorized the recommendations.	F 756		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure each resident's medication regimen is free from a medication error rate of 5% or greater. Based on 25 opportunities observed during the medication administration task, there were 2 errors resulting in an error rate of 8%. Findings are as follows: 1. Record review revealed Resident ID #3 has a physician's order dated 8/17/2018 for Lactulose (a medication used to treat constipation) Oral Solution 10 GM (gram)/15 ML (milliliter), administer 30 ml by mouth twice a day, every morning and evening. During a surveyor observation of the medication administration task with Certified Medication Technician (CMT), Staff C, on 11/15/2023 at 9:15 AM, revealed she administered 22 ml of Lactulose instead of 30 ml as ordered by the physician.	F 759	As a Plan of Correction (POC) for Federal Tag F 759 a) Residents ID # 3 and 5 are receiving their medications according to physicians' orders and in accordance with specific administration instructions, considering resident #5 exercises [redacted] right(s) to refuse at times. b) Residents in the facility who take medications have the potential to be affected by this finding. We are monitoring medication passes to ensure medication is measured correctly and that special instructions for administration are being followed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 14 During a surveyor interview immediately following the above observation with Staff C, she acknowledged she did not administer the Lactulose as ordered. Staff C stated "I can't see very good." 2. Record review revealed Resident ID #5 has a physician's order dated 3/15/2022 for Omeprazole (a medication used to treat acid reflux, ulcers) capsule delayed release, 20 milligrams, administer 1 capsule by mouth, once a day at 7:00 AM. Review of the medication blister package revealed an instruction on the package which indicates to administer before meals. During a surveyor observation of the medication administration task with Staff C on 11/15/2023 at 8:22 AM revealed she administered the Omeprazole to the resident after the resident already had his/her breakfast. During a surveyor interview immediately following this observation with Staff C, she acknowledged she did not administer the above medication as ordered. During a surveyor interview with the Director of Nursing Services on 11/15/2023 at 9:30 AM, she acknowledged the above-mentioned errors. Additionally, she indicated she would expect that the staff would administer medications as ordered and to follow the instructions on the blister package.	F 759	c) We have provided education to the nurses and med techs related to the accurate measurement of liquid medications and paying attention to specified medication times in relation to meals. We are doing random medication pass observations to monitor for compliance with timing and other administration instructions and techniques of medication preparation to include measuring liquid medications. d) The DNS/designee is responsible for implementing this plan. The results of the medication pass observations will be conducted on a routine basis and the results shared with the QAPI committee for no less than 3 months; at which time, we will determine the need/frequency to continue formal observations.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 15 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842	As a Plan of Correction (POC) for Federal Tag F 842 a) Resident ID # 28 has expired. We have included an addendum to [redacted] medical records indicating our acknowledgment of the inaccuracies in the medical record that were identified during the survey. b) Residents who reside in the facility have the potential to be affected by this finding. We have reviewed advance directive documents to ensure consistency between the documents and medical record face sheet entries. Revisions were made as necessary. c) We have educated the members of the IDT on the importance of accurate documentation and the need for consistency in the information. We have alerted the IDT and nurses to be alert to any discrepancies observed in the medical record and the need to bring the information forward to leadership for correction. if identified. We have developed an audit tool to monitor our progress towards compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 16 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it has been determined that the facility failed to maintain medical records on each resident that are accurately documented for 1 of 3 residents reviewed for COVID-19, Resident ID #28. Findings are as follows: a. Record review revealed that the resident was readmitted to the facility in September of 2021 with diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD,	F 842	d) The DNS/Designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 3 months; at which time, we will determine the need/ frequency to continue formal audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 17 lung disease) and type II diabetes mellitus. Record review revealed that the resident expired on 8/18/2023. Review of the banner on the electronic medical record revealed that the resident's advanced directives were full code (wants resuscitation and all life saving measures performed in a medical emergency). Review of the resident's closed medical record revealed a signed Advanced Directive for Do Not Resuscitate (DNR) and comfort measures (CMO). During a surveyor interview on 11/15/2023 at 11:54 AM with Registered Nurse (RN), Staff A, she revealed that the resident's signed advanced directive was DNR/CMO and life saving measures were not performed prior to him/her expiring. During a surveyor interview on 11/15/2023 at 8:55 AM with the Director of Nursing Services she acknowledged that the banner on the resident's electronic medical record did not match his/her signed advanced directives. b. Record review revealed that the resident expired on 8/18/2023. Review of the August 2023 Vital Signs report revealed an entry for the resident's temperature of 98.2 degrees on 8/19/2023 at 9:29 AM. During a surveyor interview on 11/15/2023 at 8:55 AM with the Director of Nursing Services she was unable to explain why a temperature was	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 18 recorded in the resident's medical record a day following his/her death. Additionally, she was unable to provide evidence that the facility maintained accurately documented medical records.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880	As a Plan of Correction (POC) for Federal Tag F 880 a) CMT Staff C and Nurse B were reeducated on the importance of stand precautions. Standard precautions are in use for residents ID # 3, 5, 18, and 180 related to handwashing and for residents ID# 13, 24, 79 and 129 related to care items being brought into resident rooms. b) Residents in the facility have the potential to be affected when standard precautions are not followed. We continue to monitor for breaches and make corrections as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 19 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined that the facility failed to follow standard precautions (basic level of infection control that should be used at all	F 880	c) We have provided education to the clinical staff related to blood borne pathogens. We have emphasized the use of standard precautions, specifically the importance of handwashing and the sanitizing of multiuse equipment between use. We have asked our infection preventionist to increase monitoring and surveillance, to provide on the spot education and on- going education related to standard precautions. We have devised an audit tool to ensure compliance with this plan. d) The DNS/designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 3 months; at which time, we will determine the need/ frequency to continue formal audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 20 times, example: hand hygiene) to prevent the spread of infection relative to hand washing during the Medication Administration task for Resident ID #s 3, 5, 18 and 180 and placement of a glucometer supply basket during the morning blood glucose monitoring for Resident ID #s 13, 24, 79 and 129. Findings are as follows: Review of a facility policy titled "General and Medication Administration...Procedure" states in part, "...2. Prior to preparing or administering medications, authorized and competent Facility staff should follow facility's infection control policy (e.g., handwashing)..." 1. During a surveyor observation on 11/15/2023 of the Medication Administration task with Certified Medication Technician, Staff C, she was observed administering medication to the following residents without performing hand hygiene between residents at the following times: - 8:22 AM - Resident ID #5 - 8:41 AM - Resident ID #180 - 9:09 AM - Resident ID #18 - 9:15 AM - Resident ID #3 Additionally, Staff C was observed at 8:41 AM, wearing gloves and then she was observed to touch the kitchen door keypad and wiping the table with her gloved hands. She then proceeded to administer Resident ID #180's eye drops without changing her gloves or performing hand hygiene. During a surveyor interview following this observation, she acknowledged that she failed to	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 21 perform hand hygiene throughout the Medication Administration task. Additionally, she indicated that she failed to change her gloves after she touched the door keypad and wiped the table. During a surveyor interview on 11/15/2023 at approximately 10:00 AM with the Director of Nursing Services (DNS), she indicated that she expects Staff C to follow standard precautions while administering the residents' medication. 2. During a surveyor observation on 11/15/2023 at 7:43 AM, Registered Nurse, Staff B ,was observed taking the glucometer supply basket to Resident ID #13's room and placed it on the bed while she was checking his/her blood glucose. During further surveyor observation, Staff B was observed at 7:55 AM taking the same glucometer supply basket that has not been sanitized to the dining room and placed it on a table while she checked Resident ID #22's blood glucose. During additional surveyor observations on 11/15/2023, Staff B was observed placing the same glucometer basket that had not been sanitized on the following residents' beds. - 8:05 AM - Resident ID #24 - 8:12 AM- Resident ID #79 - 8: 18 AM- Resident ID #129 During a surveyor interview immediately following the above-mentioned observations, Staff B acknowledged taking the same basket to multiple rooms without sanitizing it. During a surveyor interview on 11/15/2023 at approximately 10:00 AM with the DNS, she	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HEALTH CARE CENTER NORTH	60 EBEN BROWN LANE CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 22 indicated that Staff B should not have brought a basket of supplies from one room to another without sanitizing it in between.	F 880		