STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415034	A. BUILDING _____ B. WING _____	04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND ISLANDER CENTER	333 GREEN END AVENUE MIDDLETOWN, RI 02842

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F 000	INITIAL COMMENTS A Recertification Survey and complaint investigation ACTS reference numbers 78978, 78545, 77507, 77487, 78162 was conducted at Grand Islander Center from 03/29/2021 through 04/01/2021 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. A State licensure and emergency preparedness surveys were also conducted at this facility. As a result of this survey, the Facility was determined to not be in compliance with these requirements.	F 000	In filing an acceptable plan Of correction, we seek to Comply with federal survey and certification requirements. However, the filing os the Acceptable plan of correction Does not constitute an admission That the alleged deficiency exists.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609	**F 609** **Corrective Action**: Resident ID#60 had interventions in place added to address resident positioning and providing staff education about fragile skin. The bruise resolved on 3/29/21. 4/30/2021 **Identification of other Residents**: A review of skin checks will be completed by 4/23/21 to ensure no other residents had any bruises with no known source. **Systematic Changes:** Nursing staff will be re-educated on 4/21/21 about reporting bruises, investigating causes, and if necessary reporting to RIDOH. **Monitoring:** Weekly audits of records to be completed by CNE or designee for 1 month, then monthly for 3 months followed by quarterly review at QAPI to ensure compliance. The QAPI team will determine the need for further auditing when compliance is achieved. The CED is responsible for oversight.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Allan Downey — TITLE: CED/Administrator — (X6) DATE: 4/16/2021

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.

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F 609	Continued From page 1 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. 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 an alleged violation involving injuries of unknown source was reported immediately, but not later than 24 hours after the allegation was made, in accordance with State law through established procedures, for 1 of 4 sample residents reviewed for abuse, Resident ID #60. Findings are as follows: The facility policy titled, "Accident/Incidents" states in part, "...An incident is defined as any occurrence not consistent with the routine operation of the Center or normal care of the patient...The CED (Center Executive Director) and/or CNE (Center Nurse Executive) will verify that state reporting occurs within required timeframes and via appropriate method of reporting..." Record review revealed Resident ID #60 was admitted to the facility in April 2017 with diagnoses to include, but not limited to: dementia with behavioral disturbances, need for assistance with personal care, reduced mobility, abnormal posture, and muscle weakness. Record review of an "SBAR (Situation, Background, Assessment, Recommendation) Communication Form and Progress Note for	F 609		

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F 609	Continued From page 2 RNs/LPN/LVNs" dated 3/19/2021 revealed a "Change in skin color or condition" completed by Staff A, Licensed Practical Nurse. Record review of the resident's care plan revealed the following: - Dependence for assistance with activities of daily living, which states in part, "...I am a mechanical lift for all transfers into my Broda chair. Staff have been educated not to leave Broda in upright position...I tend to lean over to side so, also bring arms of chair up higher and tilt chair back..." dated 7/18/2014 and revised 3/11/2021. - Risk for skin breakdown due to limited mobility, which states in part, "...Observe skin condition with ADL care daily and report abnormalities...Weekly skin assessments by licensed nurse...Assess contributing factors including environment to injury and revise plan of care to prevent further incidents..." revised 10/02/2020. - Actual skin breakdown in the form of "SkinTear/Bruise" dated 3/22/2021. Record review of physician orders revealed "Left Forearm: monitor bruise two times a day for 10 Administrations" dated 3/20/2021 and completed 3/25/2021. Record review of the nursing progress notes revealed the following: - 3/19/2021 "Change in Condition/s ...Change in skin color or condition...Nursing observations, evaluation, and recommendations are: Large	F 609	HR 4/20/21	

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F 609	Continued From page 3 bruise noted on resident left forearm, no open area noted..." - 3/20/2021 "...Wound Care...Lt (left) forearm red/purple bruise noted. Skin intact. No edema. No indication pain. Patient unable to identify cause..." - 3/21/2021 through 3/23/2021 revealed documentation related to the continued presence of the left forearm bruise. Record review of skin checks dated 3/22/2021 and 3/29/2021 revealed the resident's left forearm bruise to be "healing." The facility was unable to provide evidence that the above injury of unknown source had been reported to the State Survey Agency. During a surveyor interview on 3/31/2021 at approximately 9:40 AM, Staff B, Certified Medication Technician, indicated this resident tended to lean to the left side, so staff always used pillows under both sides to provide trunk support in addition to leaning back the chair, and when the resident was in bed. Staff B had no recall of any incidents of fall or reported accidents during care.	F 609	VK 4/20/21	
	During a surveyor interview on 3/31/2021 at approximately 9:50 AM, Staff C, Registered Nurse, indicated Resident ID #60 was totally dependent for all care, and was unable to ambulate or reposition independently. She indicated the resident was supported by pillows to ensure appropriate alignment in bed and in the Broda chair. Staff C was not aware of any accidents or incidents involving this resident.			

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F 609	Continued From page 4 During a surveyor interview on 3/31/2021 at approximately 3:05 PM, Staff A indicated she had completed an SBAR on 3/19/2021 after receiving report from the prior nurse during nurse report that this resident had a left forearm bruise. At this time Staff A indicated an area on her left forearm of approximately 3-4 inches to demonstrate the location of the bruise. She stated she "had no idea how it could have happened." Staff A also indicated this resident was dependent for all care. During a surveyor interview on 4/1/2021 at approximately 9:40 AM, the Director of Nursing acknowledged Resident ID #60 had an injury of unknown source which was not reported to the State Survey Agency within 24 hours.	F 609	In filing an acceptable plan Of correction, we seek to Comply with federal survey and certification requirements. However, the filing os the Acceptable plan of correction Does not constitute an admission That the alleged deficiency exists.	4/30/2021
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it has been determined that the facility has failed to ensure that services provided by the facility meet professional standards of quality for 1 of 5 sample residents relative to physician orders, Resident ID #37. Findings are as follows: Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, "The physician is responsible for	F 658 MR 4/20/21	**F 658** **Corrective Action**: Resident ID#37's medical orders for constipation were reviewed with the practitioner on 4/13/21 with laxative protocol reviewed and adjusted to resident's preferences. **Identification of other Residents:** A review of bowel documentation and laxative orders was completed 4/23/21to ensure laxative protocols are in place per guidelines or resident preference. **Systematic Changes:** Nursing staff will be re-educated on 4/15/21 about following MD orders for laxative protocol. **Monitoring:** Weekly audits of records to be completed by CNE or designee for 1 month, then monthly for 3 months followed by quarterly review at QAPI to ensure compliance. The QAPI team will determine the need for further auditing when compliance is achieved. The CED is responsible for oversight	

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F 658	Continued From page 5 directing medical treatment. Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm the clients." Resident record review revealed the resident was admitted to the facility in January of 2021 following a left hip fracture. Resident record review revealed the following physician orders dated 1/27/2021: 1. An order for "Milk of Magnesia Suspension 400 Mg[milligrams]/5 ml [milliliters] (Magnesium Hydroxide) Give 30 ml by mouth as needed for Constipation give at bedtime if no BM [bowel movement] in 3 days". 2. An order for "Bisacodyl Tablet Delayed Release 5 mg, give 2 tablets by mouth every 24 hours as needed for constipation at HS [hour of sleep]". 3. An order for "Dulcolax Suppository 10 mg (Bisacodyl), insert 1 suppository rectally as needed for constipation if no results from _X_MOM___Miralax by next shift". 4. An order for "Fleet Enema 7-19 GM [grams]/118 ML (Sodium Phosphates) insert 1 dose rectally as needed for Constipation if no result from Dulcolax within 2 hours. If no results from Fleet enema, call MD/advanced practice provider for further orders". Record review of the resident's bowel record on 4/1/2021 at approximately 10:00 AM revealed the resident had not had a bowel movement since 3/27/2021, which had been 4 days prior. Record review of the resident's March 2021 and	F 658	MR 4/20/21	

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F 658	Continued From page 6 April 2021 Medication Administration Record (MAR) on 4/1/2021 revealed the resident was administered Bisacodyl tablets 10 mg on 3/29/2021 at 10:57 AM and Milk of Magnesia 30 ML on 3/29/2021 at 7:14 PM. Further review of the MAR revealed the resident was administered Milk of Magnesia 30 ML again on 3/30/2021 at 9:38 AM. The March and April MAR failed to reveal medication administration for a dulcolax suppository or a fleet enema after 3/27/2021. Further record review failed to reveal medication administration for Milk of Magnesia or Bisacodyl tablets after 3/30/2021. Record review of the progress notes failed to reveal that the provider was informed that the resident had not had a bowel movement since 3/27/2021. During a surveyor interview on 4/1/2021 at 12:12 PM with the Director of Nursing, she was unable to provide evidence that the above medications were administered according to the physician's order. During a surveyor interview on 4/1/2021 at 1:55 PM with the resident's Nurse Practitioner, Staff D, revealed she was unaware that the resident had not had a bowel movement since 3/27/2021.	F 658	MR 4/20/21	
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695		

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F 695	Continued From page 7 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. 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 provide respiratory care consistent with professional standards of practice for 1 of 3 residents reviewed for oxygen therapy, Resident ID #17. Findings are as follows: According to Brunner and Sudarth's textbook, Medical and Surgical Nursing, 7th Edition, 1992, p.524, "as with other medications, oxygen is administered with care, and its effects on each patient are carefully assessed. Oxygen is a drug and except in emergency situations is prescribed by a physician." According to Basic Nursing, Mosby, 3rd Edition: "after administering a drug, the nurse records it immediately on the appropriate record form. Recording the drug includes the name of the drug, dosage, route of administration and exact time of administration." Record review revealed this resident had an admission date of October 2018 with diagnoses including, but not limited to: cerebrovascular disease, anxiety disorder, and chronic obstructive pulmonary disease. Surveyor observations made on 3/29/2021 at approximately 11:40 AM; 3/30/2021 at 10:35 AM; 3/31/2021 at 9:30 AM; and 04/01/2021 at approximately 11:00 AM revealed the resident	F 695 WR 4/20/21	In filing an acceptable plan Of correction, we seek to Comply with federal survey and certification requirements. However, the filing os the Acceptable plan of correction Does not constitute an admission That the alleged deficiency exists. **F 695** **Corrective Action:** Resident ID#17's medical orders for oxygen were reviewed with the practitioner and it was determined after assessing the resident needed at bedtime and order was obtained for oxygen at 2 liters/minute when in bed at night on 4/5/21. **Identification of other Residents:** A review of residents and oxygen orders was completed 4/23/21 to ensure residents receiving O2 have correct orders in place. **Systematic Changes:** Nursing staff will be re-educated on 4/15/21 about following MD orders for oxygen use. **Monitoring:** Weekly audits of records to be completed by CNE or designee for 1 month, then monthly for 3 months followed by quarterly review at QAPI to ensure compliance. The QAPI team will determine the need for further auditing when compliance is achieved. The CED is responsible for oversight	4/30/2021

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F 695	Continued From page 8 was receiving oxygen via nasal cannula (a device used to deliver supplemental oxygen or increased airflow to a patient) at 2 liters per minute. Record review failed to reveal a current order for oxygen therapy. However, there was a prior order for "Oxygen via NC (nasal cannula) @ 2 L (liter) every shift for desat (desaturation)" with a start date of 5/28/2020 and a discontinuation date of 6/25/2020. The record failed to reveal evidence of additional oxygen related physician orders after 6/25/2020. Record review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) failed to reveal documentation of oxygen administration from 6/25/2020-4/1/2021. Further record review of the resident's "Vital: O2 (oxygen) sats (saturation)" taken from 6/26/2020-4/1/2021 revealed approximately 480 documented oxygen saturation percentages which state "Oxygen via Nasal Cannula." During a surveyor interview on 4/1/2021 at approximately 1:30 PM, the Director of Nursing was unable to provide evidence that a physician's order was obtained for oxygen after 6/25/2020.	F 695	NLR 4/20/21	
F 880 SS=E	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.	F 880		

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F 880	Continued From page 9 §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; (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	F 880	MR 4/30/21	

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F 880	Continued From page 10 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, record review and staff interview, it has been determined that the facility failed to ensure that staff utilized Personal Protective Equipment (PPE) according to professional standards and properly disinfect PPE, medication bottles, and medical equipment to prevent the transmission of infectious diseases. Findings are as follows: The Centers for Disease Control and Prevention (CDC) publication titled "RECOMMENDED INFECTION PREVENTION AND CONTROL PRACTICES WHEN CARING FOR A PATIENT SUSPECTED OR CONFIRMED SARS-COV-2 INFECTION," updated on 3/29/2021, states in part, "...Eye protection should be worn during patient care encounters to ensure the eyes are	F 880 NLK 4/20/21	In filing an acceptable plan Of correction, we seek to Comply with federal survey and certification requirements. However, the filing os the Acceptable plan of correction Does not constitute an admission That the alleged deficiency exists. In accordance with Federal regulations at 42 CFR §488.424, a DPOC is imposed on the facility. The DPOC is as follows: Starting immediately upon receipt of this enforcement letter, The Infection Preventionist and Director of Nursing, in conjunction with the Medical Director, and senior leadership/Governing Body concurrence, shall complete the following: - Conduct a root cause analysis ("RCA") by the ICP, QAPI Committee, and Governing Body. Detailed documentation of the RCA will be completed. Please note an acceptable and effective RCA will include the following elements: Identify the root cause resulting in the facility's failure. This includes asking the Who, What,	4/13/2021

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F 880	Continued From page 11 also protected from exposure to respiratory secretions..." Upon entering the facility on 3/29/2021 at approximately 9:30 AM, the Director of Nursing (DON) revealed the quarantine area for the newly admitted residents is located on the Transitional Care Unit (TCU). She requested that the survey team wear eye-protection and an N95 mask when entering the unit and to wear full PPE including eye-protection, N95 mask, gown, and gloves when entering a quarantine room. During a surveyor interview on 3/29/2021 at approximately 11:15 AM, with the Infection Preventionist (IP), she indicated the facility follows guidelines for COVID-19 from the Center for Disease Control (CDC) and Rhode Island Department of Health (RIDOH), whichever is more stringent. During a surveyor observation on 4/1/2021 at 8:22 AM, signage posted on the door of Resident ID #416, stated in part, "Patient specific contact precautions plus airway precautions for special respiratory circumstances STOP...wear an N-95 /approved KN95 respirator, gown, face shield, and gloves upon entering this room. Staff Nurse E, was observed exiting the room wearing a surgical mask and no eye protection..." During a surveyor interview immediately following the observation mentioned above, Staff Nurse E acknowledged that she did not wear proper PPE while she was in the resident's room providing care. During a surveyor interview on 4/01/2021 at 9:10 AM, with the IP, she indicated she would expect	F 880	Where, When, and Why questions which can be done by conducting internal investigations; Develop solutions and systemic changes that need to be taken to address the root cause; and Implement the solution. The RCA should focus on infection control issues relative to personal protective equipment (PPE) and proper disinfection methods to prevent the transmission of infectious diseases. The RCA should be completed by 4/13/2021. - The Medical Director, Administrator, Director of Nursing and the facility's ICP, will review and revise all infection control policies, procedures, and protocols to ensure they correlate to the current United States Centers for Disease Control and Prevention's (CDC) guidelines and recommendations. This shall be completed immediately and then AT LEAST every two weeks for the next six months. - All staff and contracted direct care staff will be in-serviced on infection control issues relative to PPE and proper disinfection methods to prevent the transmission of infectious diseases. The in-service should be completed by 4/13/2021. - A QAPI must be completed and should focus on infection control issues relative to PPE and proper disinfection methods to prevent the transmission of infectious diseases. The QAPI should be completed by 4/13/2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415034	A. BUILDING _____ B. WING _____	04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 12 staff to follow the signage posted on the doors of resident's rooms and wear the proper PPE indicated. During a surveyor interview on 4/01/2021 at 9:59 AM, with the Clinical Quality Specialist and the DON, they acknowledged that staff should follow signage posted on the resident's doors and wear the proper PPE indicated including N95 masks, gowns, and gloves when entering a quarantine room for droplet/contact precautions. During a surveyor observation of Resident ID #413's room, a quarantine room on 4/1/2021 at 9:12 AM, immediately following the medication pass with Staff Nurse F, revealed the following: Staff F was observed to be holding 3 medication bottles while simultaneously pulling the vital sign machine as she exited the quarantine room. She was then observed placing the medication bottles on the shelf of the vital sign machine. Further observation failed to reveal that Staff F disinfected the medication bottles or the vital sign machine after exiting the resident's room. Staff F was then observed opening a drawer in the medication cart, placing one of the medication bottles in its container, without disinfecting the bottle. She then took the remaining 2 medication bottles off the contaminated vital sign machine and retrieved the third medication bottle from the medication cart drawer and placed all 3 bottles on top of the medication cart. Staff F then wiped down each bottle with a disinfectant wipe and placed all 3 bottles back on the vital sign machine. Observation failed to reveal that Staff F disinfected the vital sign machine.	F 880	WLR 4/20/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 13 Additionally, Staff F failed to remove or disinfect her face shield prior to exiting the room. Staff F was then observed to remove her face shield and place it on the medication cart. She then picked up the face shield off the cart cleaned it with a disinfectant wipe and placed it back down on the medication cart. Observation failed to reveal that Staff F disinfected the medication cart. During a surveyor interview with Staff F immediately following the above mentioned observations, she acknowledged the breeches in her infection control practices. During a surveyor interview on 4/01/2021 at 12:48 PM with the DON she acknowledged the above observation was a breech in infection control practices.	F 880	MR 4/20/21	