STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415083	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastgate Nursing & Rehabilitation Center	198 Waterman Avenue East Providence, RI 02914

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to implement a comprehensive person-centered care plan related to skin integrity for 1 of 1 resident observed, Resident ID #50, and a Hoyer lift (mechanical lift) transfer for 1 of 4 residents reviewed, Resident ID #48. Findings are as follows: Record review of the State Operations Manual (SOM) Appendix PP-Guidance to Surveyors for Long Term Care Facilities, updated on 8/8/2024, page 316 revealed that many clinicians recommended a position change (offloading) hourly for dependent residents who are sitting or who are in a bed or a reclining chair with the head of the bed or back of the wheelchair raised 30 degrees or more. Further review of the SOM revealed a micro shift, meaning a small change in the resident's position for a short period of time, may not be adequate since this approach does not allow sufficient capillary refill and tissue perfusion for a resident at risk of developing a pressure injury. 1. Record review for Resident ID #50 revealed s/he was admitted to the facility in August of 2023 with diagnoses including, but not limited to, dementia, cerebral infarction (stroke), and abnormal gait and mobility. Record review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 4 out of 15, indicating severe cognitive impairment. Record review of a care plan dated 6/5/2024 revealed the resident is unable to be independent with self-care secondary to physical limitations related to being status post stroke with right sided weakness, periods of increased confusion due to dementia, and a decline in physical and mental status. Further record review revealed a care plan dated 3/2/2024 that indicated the resident is at risk for skin breakdown due to impaired mobility, bowel incontinence, and fluctuation in intake. Interventions included, but were not limited to, receiving assistance with repositioning, incontinence care, or toileting during unit rounds, and as needed. Continuous surveyor observations revealed the resident was sitting in his/her Broda (a type of wheelchair) with the back of the chair reclined at approximately 75 degrees. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The staff failed to assist the resident with repositioning, incontinence care, and/or toileting during the following continuous observations: -11/20/2024 from 9:45 AM through 1:50 PM (4 hours and 5 minutes) -11/21/2024 from 7:45 AM through 12:05 PM (4 hours and 20 Minutes) During a surveyor interview on 11/21/2024 at 12:08 PM with NA, Staff B, she revealed that the resident was on her assignment. Staff B further revealed that the resident was assisted out of bed to his/her wheelchair this morning between 7:30 AM and 7:45 AM, although Staff A had previously stated to the surveyor that the resident was in his/her chair at 7:00 AM. Additionally, Staff B revealed she has not repositioned, provided incontinence care, and/or toileted the resident. During a surveyor interview on 11/21/2024 at 12:12 PM with the Director of Nursing Services (DNS), she revealed ideally, staff should do their rounds (check for incontinence and repositioning) every 2 to 3 hours. When she was made aware of the above mentioned observations. The DNS stated, that is not acceptable. During a surveyor observation in the presence of the DNS on 11/21/2024 at 1:44 PM, revealed that the resident had a bowel movement. During a surveyor interview following the above observation with the DNS, she was unable to provide evidence that Resident ID #50's comprehensive person-centered care plan was followed. 2. Record review revealed Resident ID #48 was admitted to the facility in May of 2022 with diagnoses including, but not limited to, left side hemiparesis and hemiplegia (partial weakness and paralysis). Record review of a Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, indicating intact cognition. During a surveyor interview on 11/18/2024 at 11:02 AM, and again on 11/19/2024 at 10:10 AM with Resident ID #48, s/he revealed that s/he was concerned for her/his safety because NA, Staff C, has been transferring her/him alone while utilizing the Hoyer lift. Record review of a care plan dated 2/26/2024 indicated the resident is a fall risk with interventions including, but not limited to, transfer via Hoyer lift with the assistance of two staff. During a surveyor interview on 11/19/2024 at 3:06 PM with NA, Staff C, she acknowledged two staff members are required to transfer a resident via a Hoyer lift. Additionally, she revealed that she has transferred the resident alone at times. During a surveyor interview on 11/19/2024 at approximately 3:15 PM with the DNS, she revealed that her expectation is to have two staff members present during Hoyer lift transfers per the resident's plan of care.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide a resident with limited range of motion (ROM) appropriate treatment and services relative the use of a hand roll device (use to promote extension in contrasted hand) for 1 of 1 resident reviewed, Resident ID #32. Findings are as follows: Record review revealed the resident was admitted to the facility in July of 2017 with a diagnosis including, but not limited to, left hand contractures. Record review of the care plan dated 3/5/2024 revealed the resident is unable to be independent with self-care secondary to physical limitations. Record review of a physician's order dated 4/5/2024 revealed that the resident is to wear a left-hand roll with finger separators every morning for 6-8 hours, as tolerated. Record review of an Occupational Therapist (OT) note dated 11/11/2024, revealed that the resident was screened for the left-hand roll with finger separators and that s/he is appropriate to wear the device. During surveyor observations on the following dates and times, failed to reveal evidence that the left-hand roll with finger separators was in place: - 11/18/2024 at 12:16 PM - 11/19/2024 at 7:54 AM, 10:55 AM, and 12:00 PM - 11/20/2024 at 9:16 AM, and 11:40 AM During a surveyor observation of the resident in the presence of Licensed Practical Nurse, Staff D, on 11/20/2024 at 11:48, she acknowledged that the resident did not have his/her left-hand roll in place. Additionally, Staff D indicated that the resident might have refused. During the above interview, the resident responded to Staff D that s/he never refused the use of the hand roll. Furthermore, Staff D then applied the hand roll to the resident's left-hand. During a surveyor interview on 11/20/2024 at 12:00 PM with OT, Staff H, she indicated that the purpose of the left-hand roll is to keep the resident's left hand opened as much as possible, due to his/her contractures. During a surveyor interview on 11/20/2024 at 1:41 PM with the Director of Nursing Services, she indicated that she would have expected the staff to apply the left hand roll to the resident's hand unless it was refused.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 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 relative to the failure to post cautionary and safety signs indicating that oxygen was in use for 3 of 3 residents observed, Resident ID #s 13, 36, and 52. Findings are as follows: 1. Record review revealed Resident ID #52 was admitted to the facility in May of 2024 with a diagnosis including, but not limited to, acute and chronic respiratory failure with hypoxia (low levels of oxygen in the blood). Record review revealed a physician's order dated 8/20/2024 to administer humidified oxygen at 2 liters per minute (LPM) continuously via a nasal cannula (a medical device used to provide supplemental oxygen therapy). Surveyor observation of the resident's room failed to reveal evidence that a cautionary and safety sign indicating oxygen was in use on the following dates and times: - 11/18/2024 at 9:09 AM and 11:31 AM - 11/19/2024 at 8:07 AM - 11/20/2024 at 8:02 AM During a surveyor interview on 11/20/2024 at 8:13 AM with the RN, Staff E, she acknowledged that Resident ID #52's room failed to have a cautionary and safety sign indicating oxygen was in use. 2. Record review revealed Resident ID #13 was admitted to the facility in November of 2014 with a diagnosis, including but not limited to, alcohol dependence. Record review revealed a physician's order dated 10/29/2024 to administer oxygen at 2 LPM via nasal cannula every shift. Surveyor observations of the resident's room failed to reveal evidence that a cautionary and safety sign indicating oxygen was in use on the following dates and times: - 11/18/2024 at approximately 10:30 AM - 11/20/2024 at 8:04 AM and 8:31 AM During a surveyor interview on 11/20/2024 at 8:31 AM with Registered Nurse (RN), Staff E, she acknowledged that Resident ID #13's room failed to have a cautionary and safety sign indicating oxygen was in use. 3. Record review revealed Resident ID #36 was admitted to the facility in October of 2024 with a diagnosis including, but not limited to, malignant neoplasm of the rectum (rectal cancer). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed a physician's order dated 11/18/2024 to administer oxygen at 2 LPM continuously via a nasal cannula. Surveyor observations of the resident's room failed to reveal evidence that a cautionary and safety sign indicating of oxygen was in use on the following dates and times: - 11/18/2024 at approximately 1:00 PM - 11/19/2024 at 8:54 AM and 9:44 AM During a surveyor interview on 11/20/2024 at approximately 1:00 PM with the Director of Nursing Services, she acknowledged that the facility failed to have a cautionary and safety sign indicating oxygen was in use for the above residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that food is stored and distributed in accordance with professional standards for food safety relative to food handling, and 1 of 1 ice machines observed. Findings are as follows: 1. Record review of the Rhode Island Food Code 2018 Edition, 216-RICR-50-10-1 subchapter 10 titled food contamination, section 1.5.1 Preventing Contamination from Hands states in part, Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use .single-use gloves . During surveyor observations of the meal service in the main kitchen of cook, Staff F, he failed to follow the single-use gloves protocol on the following dates and times: - 11/18/2024 from 11:50 AM to 12:11 PM, Staff F was observed touching the following equipment (oven, microwave, knives, and tongs), and food with the same gloves. Staff F then removed salad from a salad bowl and plated it for lunch service. Further, Staff F, with the same gloves on, put on an oven mitt, over his gloved hand, removed a pan of bacon from the stove and plated the bacon. Again, without changing his gloves, Staff F was observed handling cooked chicken and bread. - 11/19/2024 at 11:55 AM, Staff F was observed touching the microwave, checking the soup temperature, the cutting board and a resident's grilled sandwich, without changing his gloves. During a surveyor interview on 11/19/2024 at 12:02 PM with Staff F, he acknowledged that he failed to change his single use gloves after handling kitchen equipment and before handling ready to eat food. During a surveyor interview on 11/19/2024 at 12:10 PM with the Food Service Director (FSD), she indicated that she would have expected Staff F to change his gloves before touching ready to eat food. 2. The Rhode Island Food Code 2018 Edition 5-202.13, states in part, .an air gap between the water supply inlet and the flood level rim of the plumbing fixture equipment .shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch) . During a surveyor observation, in the presence of the FSD on 11/20/2024 at 9:21 AM, revealed the facility's ice machine located in the main kitchen, had an air gap between the water supply inlet and the flood level rim of approximately 0.25 inches. During a surveyor interview on 11/20/2024 at 11:20 AM with the FSD, she acknowledged that the measurement between the water supply inlet and the flood level rim is less than 1 inch as required.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary environment, and to help prevent the development and transmission of communicable diseases, relative to the disinfection of a multiuse glucometer. Findings are as follows: Record review of a facility provided document titled, Facility's Competency Validation for Blood Glucose Testing, revealed the glucometer should be wiped down with a low-level disinfectant wipe (per the manufacturer's instructions) before and after each use. Record review of the McKesson's Manufacturer Instruction Manual revealed that the glucometer is to be cleaned and disinfected only with PDI Super Sani Cloth wipes (or any disinfectant product with the Environmental Protection Agency *reg. no. of 9480-4). Record review revealed Resident ID #10 has a physician's order dated 8/24/2024 to obtain a finger stick blood sugar (FSBS) once a day at 12:00 PM. During a surveyor observation on 11/19/2024 at 11:16 AM with Licensed Practical Nurse, Staff G, she failed to wipe down the glucometer before and after obtaining the resident's FSBS. Additionally, Staff G failed to disinfect the glucometer prior to placing it back in its bag and placing it in the medication cart. During a surveyor interview on 11/19/2024 at 12:25 PM with Staff G, she acknowledged that she failed to wipe down the glucometer after she used it. Staff G then cleansed the used glucometer with an alcohol wipe. When questioned during the observation, Staff G revealed that it is her usual practice to wipe down the used glucometer with an alcohol wipe. During a surveyor interview on 11/19/2024 at 12:48 PM with the Director of Nursing Services and the Infection Control Nurse, they revealed Staff G should have wiped down the glucometer with the PDI Super Sani Cloth wipes as per the Manufacturer's instruction Manual.