| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **415020** | A. BUILDING _____ B. WING _____ | **10/08/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **GRANDVIEW CENTER** | **100 CHAMBERS STREET CUMBERLAND, RI 02864** |

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 0580<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and staff interview, it has been determined the facility failed to inform a resident's primary contact regarding the resident's change in condition for 1 of 7 sample residents, Resident ID #1. Findings are as follows: Record review revealed Resident ID #1 had an interdisciplinary care plan meeting on 09/10/2020, at which point his/her primary contact was informed s/he presented at baseline. Record review revealed the following significant changes to Resident ID #1's health from 09/11/2020-09/23/2020: -Resident ID #1 was diagnosed with [REDACTED]. -Physician orders [REDACTED].#1 had a new order for a chest x-ray on 09/13/2020, completed on 09/14/2020, indicating pneumonia due to a left lower lobe infiltrate. Physician orders [REDACTED]. -Physician orders [REDACTED]. -An APRN (Advanced Practice Registered Nurse) encounter note dated 09/16/2020 states in part .Patient seen today to assess respiratory and general status as a result of being positive for coronavirus .some shortness of breath .Oxygen as needed to maintain saturation greater than 92%. Encourage p.o. (by mouth) fluids. If patient unable to take p.o., will consider IV fluids/clysis . -An APRN encounter note dated 09/18/2020 states in part .Oxygen saturation on 2 Liter (L) was 89%. O2 was increased to 3 L, saturation up to 92% .Patient likely dehydrated. IV line placed. Normal saline infusion initiated .Patient appears ill and seems to be worsening .inability to take p.o., and worsening [MEDICAL CONDITION] . -Physician orders [REDACTED].#1 had a peripheral IV and hypodermoclysis orders dated 09/18/2020-09/22/2020. -Additional record review revealed the resident had a fall on 09/23/2020 at approximately 2:00 AM. A progress note dated 10/06/2020 states in part Spoke with POA .today. LPN called (him/her) to tell (Resident ID #1) was moved south since (his/her) Covid has resolved. (POA) was worried because (he/she) was never called and told that (Resident ID #1) had Covid .Writer apologized .and went over (his/her) treatment . During an interview on 10/08/2020 at approximately 1:00 PM, the Administrator indicated she was informed of the communication failure after Staff A, LPN spoke with Resident ID #1's primary contact on 10/06/2020, but had not been aware prior, that Resident ID #1's primary contact had not been notified of the numerous changes of condition as required. |
| F 0885<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and staff interview it has been determined the facility failed to inform a resident's primary contact regarding the resident's COVID-19 positive status for 1 of 7 sample residents, Resident ID #1. Findings are as follows: Record review revealed Resident ID #1 was diagnosed with [REDACTED]. Record review revealed no indication of communication to Resident ID #1's primary contact regarding the resident's COVID-19 status by 5 PM the following day as required. A progress note dated 10/06/2020 states in part Spoke with POA .today. LPN called (him/her) to tell (Resident ID #1) was moved south since (his/her) Covid has resolved. (POA) was worried because (he/she) was never called and told that (Resident ID #1) had Covid .Writer apologized .and went over (his/her) treatment . During an interview on 10/08/2020 at approximately 1:00 PM, the Administrator acknowledged that Resident ID #1's family member was not contacted regarding his/her COVID until 10/06/2020. |

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.