STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415096	A. BUILDING _____ B. WING _____	**03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETHANY HOME OF RHODE ISLAND	**111 SOUTH ANGELL STREET PROVIDENCE, RI 02906**

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 -** Some	**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 record review and staff interview, it has been determined that the facility failed to develop and implement a comprehensive person-centered care plan for 2 of 12 resident's reviewed ID #'s 8 and 16. Findings are as follows: 1. Record review for ID #8 revealed the resident was admitted to the facility in January of 2020 with [DIAGNOSES REDACTED]. Review of an admission minimum data set (MDS) dated [DATE] revealed the resident required extensive assist from 1 person for walking and was only able to stabilize with staff assistance. The Care Area Assessment (CAA) Summary for the above stated MDS indicated the resident was at risk for falls, proceed with care plan. Record review revealed the resident sustained [REDACTED]. There was no evidence that a care plan was in place for fall prevention prior to the resident sustaining a fall. Further record review of the CAA summary for the above mentioned MDS revealed Resident ID #8 was at risk for pressure ulcers, proceed to care plan. There was no evidence that a care plan was in place for prevention of pressure ulcers. 2. Record review for ID #16 revealed the resident was admitted to the facility in January of 2020 with [DIAGNOSES REDACTED]. Review of an MDS dated [DATE] revealed the resident is an extensive assist of 2 people for transfers. The CAA summary indicateded the resident is at risk for falls, proceed with care plan. There was no evidence of a care plan for fall prevention. An interview was conducted with the MDS nurse on 3/12/2020 at 2:18 PM. She could not provide evidence of the care plans mentioned above.
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 and staff interview, it has been determined that the facility failed to properly store food in accordance with professional standards for food service safety relative to 1 of 1 kitchenette. Findings are as follows: Surveyor observation of the 2nd floor kitchenette on 3/11/2020 at 11:34 AM revealed the following: 1. 1 of 2 Lyons Ready Care Thickened Cranberry Cocktail juice, 2 of 2 Lyons Ready Care Thickened Apple juice, 1 of 3 Lyons Ready Care Thickened Orange juice, 1 of 1 Lyons Ready Care Thickened Dairy Drink, and 1 of 2 Lyons Ready Care Thickened Water were in the refrigerator, open and not dated. Instructions on the container state to use within 7 days of opening. 2. 1 of 2 Hormel Med Pass 2.0 Vanilla Fortified Nutritional Shake in the refrigerator, open and not dated. Instructions on the container state to consume product within 4 days after opening, if properly refrigerated. 3. 17 Mighty Shakes in the refrigerator, thawed and not dated. Instructions on the container state to use within 14 days after thawing. During a surveyor interview on 3/11/2020 at 12:39 PM with the Food Service Director, he acknowledged that the above products should have been dated as per the manufacturer's instructions.

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.