STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415098	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HARRIS HEALTH CENTER LLC	833 BROADWAY 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.

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **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 protect the resident's right to be free from abuse for 1 of 4 residents reviewed for abuse (ID #1). Findings are as follows: Record review revealed that Resident ID #1 was admitted to the facility in May 2019 with [DIAGNOSES REDACTED]. Review of an Annual Minimum Data Set (MDS) on 4/16/2020 revealed that s/he is severely cognitively impaired. Review of a care plan initiated on 5/19/2019 and updated on 3/26/2020 revealed Resident ID #1 has impaired cognition due to a [DIAGNOSES REDACTED].#1's nursing progress note on 7/13/2020, written by agency nurse (Staff B) revealed the following: - Resident ID #1 was pushed and hit in the chest by another resident (Resident ID #2) who was combative and going after a staff member. No injury, no bruising or redness was noted. Resident ID #1 was unable to be interviewed as s/he is severely cognitively impaired. Record review revealed that Resident ID #2, was admitted to the facility in December 2019 with [DIAGNOSES REDACTED]. Review of a quarterly MDS assessment on 5/26/2020 revealed that a Brief Interview for Mental Status (BIMS) was not able to be conducted as the resident is rarely/never understood. Further review of the MDS revealed that Resident ID #2's cognitive skills for daily decision making are severely impaired. Review of a care plan, updated on 6/24/2020, for Resident ID #2 revealed the following: - Resident has socially inappropriate/disruptive behavioral symptoms as evidenced by intrusiveness, touching of others. - Resident was having an issue with touching others inappropriately. At this time resident is yelling more often. - Resident wanders aimlessly and has impaired safety awareness. Review of Resident ID #2's nursing progress note on 7/13/2020, written by Staff B revealed the following: - Resident ID #2 had another incident of going after staff, running towards staff and pushing elderly resident (Resident ID #1) out of the way and hitting him/her in the chest. Resident ID #1 was not hurt and had no marks or bruising to his/her chest. No injury to staff and Resident ID #2 was very difficult to redirect. Resident ID #2 was unable to be interviewed as s/he is severely cognitively impaired. During a surveyor interview on 7/16/2020 at 1:47 PM with agency nurse (Staff B), she revealed that she witnessed the above incident on 7/13/2020 and confirmed that Resident ID #2 was attempting to go after staff in the hallway, and in the process, s/he hit Resident ID #1 in the chest as s/he intentionally pushed him/her out of the way. Staff B also revealed that Resident ID #1 has a history of being combative, especially towards the staff. During a surveyor interview on 7/16/2020 at 4:18 PM with both the Director of Nursing and the Administrator, they could not provide evidence that Resident ID #1 was free from abuse.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **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 ensure that all alleged violations involving abuse, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse, to the administrator of the facility and to other officials in accordance with State law for 1 of 4 residents reviewed for abuse, Resident ID #1. Findings are as follows: Review of the Facility Policy, titled, Abuse Prohibition states in part, .any instance of actual or suspected abuse, neglect, mistreatment, involuntary confinement, misappropriation of resident property, including injuries of unknown origins including bruises, skin tears, or lacerations must be reported immediately to the DNS/designee (i.e.(that is), CN (Charge Nurse) or supervisor on duty) and an incident report is to be filled out. If the DNS (Director of Nursing)/designee is not available, the Charge Nurse must report to the Nursing Home Administrator by immediate, direct, verbal contact. The Department of Health and the Alliance for Better Long-Term Care will be contacted of allegations of abuse, neglect, mistreatment and or misappropriation of resident property immediately but no later than 2 hours after the allegation . Record review revealed that Resident ID #1, was admitted to the facility in May 2019 with [DIAGNOSES REDACTED]. Record review revealed that Resident ID #2, was admitted to the facility in December 2019 with [DIAGNOSES REDACTED]. Review of the nursing progress notes for Resident ID #1 revealed the following: - On 7/13/2020 at 6:16 PM, agency nurse (Staff D) wrote that Resident ID #2 had another incident of going after staff, running towards staff and pushed Resident ID #1 out of the way, hitting him/her in the chest. Resident ID #1 was not hurt and had no marks or bruising to the chest. Further record review failed to reveal evidence that staff reported the above alleged abuse to the facility or to the State Survey Agency. During a surveyor interview on 7/16/2020 at 1:47 PM with Staff D, she revealed that she did not report the incident to anyone. During a surveyor interview on 7/16/2020 at 4:19 PM with the Director of Nursing and the Administrator, they acknowledged that Staff D did not report any of her observations of the above incident to them or to the State Survey Agency. Additionally, they stated that they expect their staff to report any allegations involving abuse.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Respond appropriately to all alleged violations.** **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 ensure that all alleged violations are thoroughly investigated for 1 of 1 reportable allegations of elopement (ID #1) and 1 of 1 reportable allegation of abuse (ID's #1 and 2). Findings are as follows: 1) Clinical record review revealed that Resident ID #1 has [DIAGNOSES REDACTED]. An annual Minimum Data Set ((MDS) dated [DATE] indicates a Brief Interview for Mental Status (BIMS) score of 6 of 15, indicating the resident has severe cognitive impairment. Record review of a progress note dated 7/8/2020 at 10:50 PM revealed Resident ID #1 eloped from the facility and walked to a local Chiropractors office on the same street. Police notified the facility, and a Certified Nursing Assistant (CNA) went to retrieve the resident. During a surveyor interview on 7/14/2020 at 10:50 AM with the Administrator, he revealed that he was not aware what door the resident exited because he had not yet viewed the surveillance video. Further record review failed to reveal any staff statements relative to the incident. During a survey interview on 7/14/2020 at 11:05 AM with the Director of Nursing Services she could not provide evidence of a thorough investigation. 2) Record review revealed that Resident ID #2, was admitted to the facility in December 2019 with [DIAGNOSES REDACTED]. Review of Resident ID #2's progress notes on 7/13/2020 revealed the following: - At 6:16 PM: Resident ID #2 had another incident of going after staff, running towards staff pushing elderly resident (Resident ID #1) out of the way and hitting him/her in the chest. Resident ID #1 was not hurt and had no marks or bruising to his/her chest. No injury to staff. Very difficult to redirect. During a surveyor interview on 7/16/2020 at 4:18 PM with both the Director of Nursing and the Administrator, they could not provide evidence of a thorough investigation for the above incident.
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**

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.

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F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) **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 each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 2 out of 3 residents reviewed for elopement risk (ID #'s 1 and 3). Findings are as follows: 1) Record review for Resident ID #1 revealed a care plan dated 09/12/2019 which revealed a Problem of .an elopement risk due to a [DIAGNOSES REDACTED]. Interventions include, complete Elopement risk assessment upon admission, quarterly and PRN (as needed) .Notify md of any changes in mood, behavior or wandering/elopement attempts . Record review failed to reveal evidence that elopement risk assessments were completed quarterly as indicated on the resident's care plan. Record review failed to reveal evidence that the residents physician was contacted regarding the resident's elopement on 7/8/2020 at 9:00 PM. During this elopement the resident left the facility through a basement door and ambulated approximately 500 feet into a Chiropractors office. 2) Record review of Resident ID #3's elopement assessments dated 6/4/2019 and 7/14/2020 revealed the resident to be an elopement risk. They further reveal that 15-minute checks were to be initiated. Record review on 7/16/2020 of the resident's medical record lacked evidence of a care plan related to elopement. During surveyor interview on 7/16/2020 at approximately 3:30 PM with the Director of Nursing Services she was unable to provide evidence that elopement assessments were completed quarterly and the MD was notified of the elopement on 7/8/2020 for Resident ID #1. Additionally, she was unable to provide evidence of a care plan related to elopement or 15-minute checks for Resident ID #3.
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **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 ensure that the resident environment remains as free of accident hazards as possible, and that residents are provided with adequate supervision to prevent elopement for 3 of 3 sampled residents at risk for elopement (ID's #1, 2 and 3). Findings are as follows: The facility's policy titled Elopement Procedure, reveals in part, It is the policy of this facility to provide a safe and secure environment for all residents. In order to achieve this goal, residents are to be monitored at all times . DEFINITIONS: .Elopement- leaving the facility without permission and/or notification to the facility . The Administrator/Designee will: 1. Notify the resident's legal guardian or designated person as well as the primary physician . 1) Resident ID #1 was admitted to the facility in May 2019 with [DIAGNOSES REDACTED]. An annual Minimum Data Set ((MDS) dated [DATE] indicates a Brief Interview for Mental Status (BIMS) score of 6 out of 15, indicating the resident has severe cognitive impairment. On admission s/he was assessed as confused. The admission fall risk assessment revealed s/he had a score of 10 indicating high risk and revealed his/her mental status as intermittent confusion, poor recall, judgement or safety awareness. The admission assessment also revealed s/he was an elopement risk and had psych consult, social services consult and 15-minute check interventions to be initiated. Review of Resident ID #1's current care plan revealed a problem start date of 9/12/2019, stating that the resident is an elopement risk due to [DIAGNOSES REDACTED].Notify md of any changes in mood, behavior or wandering/elopement attempts . On 7/9/2020, the facility reported an incident of elopement by Resident ID #1, that occurred on 7/8/2020 at approximately 9 PM. The facility is in an urban setting, along the North side of the building is a one-way street, along the front of the build is a heavily traveled main street. Surveyor interview on 7/14/2020 at approximately 10:50 AM with the Director of Nursing (DNS) and the Administrator, revealed that a Certified Nursing Assistant (CNA) notified the nurse that the resident, last seen sleeping in his/her bed at 8:30 PM, was unable to be located. While the staff was searching the facility, the local police called the facility and informed them that this resident has been located at a nearby Chiropractic office. Following this telephone call a CNA walked to the chiropractic office to retrieve the resident. Additionally, the Administrator revealed they had not identified the door that the resident used to exit the facility, nor had they viewed the camera footage. He then stated that it was believed the resident exited the facility through a door that leads to a wheelchair ramp. He then indicated that they customarily rely on staff statements rather than the camera footage. Staff statements were requested by this surveyor. Neither the Administrator nor the DNS could provide staff statements. The DNS revealed staff statements regarding this elopement were never collected. Surveyor observation of the camera footage (requested by surveyor) on 7/14/2020 at approximately 1:00 PM, in the presence of the Administrator and DNS revealed the following: -7/8/2020 at 9:12:01 PM - resident turns corner on the first-floor hallway and walks toward the elevator. S/he is wearing pajamas, shoes and is carrying a bag. -7/8/2020 at 9:13:45 PM - resident comes out of basement elevator. (this elevator does not have any codes or alarms) Resident then walks down a hallway that ends in an exit. (There are no internal cameras directed towards this exit) -7/8/2020 at 9:17:21 PM - resident is seen exiting the basement door through a camera located outside. Ambulating in the direction of Wheldon Avenue. -7/8/2020 at 9:19:20 PM -resident is seen rounding the corner from Wheldon Avenue to the sidewalk on Broadway. -7/8/2020 at 9:20:19 PM- resident is seen walking past the front of the facility on the sidewalk. -7/8/2020 at 9:51:08 PM- resident and CNA are seen ambulating back toward the facility. The route the resident took to the Chiropractor's office was noted to be a walking distance of approximately 500 feet. During a surveyor observation on 7/14/2020 at 1:30 PM of the basement door (which was exited by the resident) in the presence of the DNS, revealed that the alarm was set to a quiet doorbell like ring. It rings twice then stops even if the door remains open. During an interview with the DNS immediately following the above observation, she indicated that this alarm would not be heard by the staff upstairs which is where the resident rooms are located. Surveyor observation of the facilities door alarms on 7/14/2020 at approximately 3:30 PM with the Administrator revealed that the exit doors were set to alarm in different manners, they were as follows: 1.) Basement door that resident exited from was set to ring twice (soft rings) when opened and then stops. 2.) Basement door near business office was not alarmed, however there is an internal door which is locked to prevent access to this area, which is alarmed. 3.) The two doors in the nurse's station hallway, had loud blaring alarms that needed to be shut off with a key. 4.) The door leading to the wheelchair ramp had an alarm set to ring when the door was opened, a code must be entered to stop this alarm. 5.) Main entrance door, at the front of building, was set to ring twice (soft rings) when opened. However, the alarm would stop even if the door remained open. 6.) An exit door located on the first-floor unit of the facility, down the hall around a corner out of view from the nursing station, that rings once when opened and then stops. Surveyor interview on 7/14/2020 at 10:35AM with the Activities Director revealed that Resident ID #1 had made it out the door unattended 2 or 3 times that she had witnessed in the past year. Surveyor interview on 7/15/2020 at 11:41 AM with Staff C revealed that Resident ID #1 is a wanderer and she goes to the doors to exit, the alarms go off and staff go retrieve her. She further revealed that when this happens the nurse is notified. Review of a Safety Events- Elopement form dated 7/8/2020 revealed the attending was not faxed, the Physician was not notified, and the resident representative was not notified. Surveyor interview on 7/15/2020 at 12:02 PM with Staff Nurse A, revealed that she had not notified the Physician or the resident's emergency contact of the elopement. She further revealed that no written statements were taken from staff and an interview of the resident was not conducted as s/he is not a reliable reporter. She further reported that no alarms went off. During a surveyor interview on 7/15/2020 at 12:31 PM with the DNS, she revealed that she was unaware that the Physician and emergency contact were not notified about the resident's elopement. She acknowledged that they should have been notified and statements should have been obtained. Additionally, she was only able to provide 15 minute checks for 7/8/2020 and 7/9/2020. 2) Resident ID #2 was admitted to the facility in December 2019 with [DIAGNOSES REDACTED]. A quarterly ((MDS) dated [DATE] indicates a Brief Interview for Mental Status (BIMS) score was unable to be conducted, indicating the resident has severe cognitive impairment. On admission s/he was assessed as confused, disoriented x 3 and had diminished safety awareness. The admission assessment revealed s/he was an elopement risk. A surveyor observation on 7/14/2020 at 11:53 AM made in the presence of the DNS, of Resident ID #2 revealed s/he was attempting to exit the building unsupervised. The alarm activated and the DNS retrieved the resident and brought him/her back inside and closed the door. Record review of the resident's progress notes revealed the following: -12/28/2019 at 3:46 PM- .resident made multiple attempts to elope this morning . -1/2/2020 at 3:05 PM- Resident was found attempting to exit the front door, where there is a steep staircase. Shortly after was attempting to exit the ramp door . -1/14/2020 at 6:14 PM- Resident noted to be ambulating down

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) ramp wearing no coat and shoes, required re-direction by staff . -1/16/2020 at 12:20 AM (late entry 7a-7p 1/15/20)- Resident with 15-20 elopement attempts throughout shift, making it outside the facility side door (by ramp) at least 10 times. - 7/8/2020 at 6:46 PM- Exit seeking, found outside on porch x 3. Grab a CNA forcefully .when she tried to stop (him/her) from going outside (DNS aware) . -7/9/2020 at 3:41 PM- .Exit seeking, found outside on porch x 2 this shift before lunch . -7/10/2020 at 5:36 PM- Resident found on front porch at 8:30 AM .exit seeking through back door onto deck .difficult to get back into facility .DNS was notified and stayed with resident through dinner . Record review of an elopement risk evaluation dated 1/20/2020, revealed that the resident is an elopement risk. It further revealed the interventions that were initiated were 15-minute checks. A copy of the 15-minute checks of this resident were requested by the surveyor for review on 7/14/2020 at approximately 10:00 AM. The DNS was unable to locate the 15-minute checks. On 7/14/2020 at 3:30PM the DNS was only able to locate the 15-minute checks sheets for 7/8/2020 and 7/9/2020 for Resident ID #2. 3) Resident ID #3 was admitted to the facility in December 2011 with [DIAGNOSES REDACTED]. A quarterly MDS dated [DATE] indicates a BIMS score of 10 of 15, indicating the resident has moderate cognitive impairment. Review of resident's elopement assessments dated 6/4/2019 and 7/14/2020 both revealed the resident to be an elopement risk. They further reveal that 15-minute checks were to be initiated. Record review of Resident ID #3's record lacked evidence of a care plan related to elopement. Record review of progress notes revealed the following: - 9/6/2019 at 11:27 PM- SW (social worker) made aware that .left the facility without making staff aware. SW and nursing contacted resident's friend .who reported resident had walked to her house .SW met with (him/her) .to remind .that (s/he) is not to leave the building on (his/her) own for safety reasons . -1/23/2020 at 4:55 PM- .has been leaving the facility unaccompanied and walking to Dunkin Donuts . SW and staff member explained .(s/he) cannot leave the building unaccompanied . During a surveyor interview on 7/17/2020 at approximately 3:45 PM with the DNS, she revealed that they are not doing 15-minute checks on Resident ID #3. She was unable to produce any evidence that 15-minute checks had ever been completed or that a care plan related to elopement was developed. The facility failed to ensure that cognitively impaired residents are provided with adequate supervision to prevent elopement. Furthermore, they failed to perform interventions for the supervision of residents found to be at risk for elopement such as 15-minute checks and development of a care plan. Additionally, they failed to assure all door alarms were able to be heard by staff, which put the residents at risk for serious injury or harm.
F 0865 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Have a plan that describes the process for conducting QAPI and QAA activities.** Based on record review and staff interview it has been determined that the facility failed to develop, implement, and maintain an effective,comprehensive, data-driven Quality Assurance and Performance Improvement (QAPI) program that focuses on indicators of the outcomes of care and quality of life. Findings are as follows: Review of the QAPI Plan 2020 failed to reveal that the facility had a process for identifying and correcting quality deficiencies including tracking and measuring performance, establishing goals and threshold for performance measurement. Further review of the QAPI also revealed that it did not address systems of care and management practices, or include clinical care, quality of life, and resident choices. During a surveyor interview with the Director of Nursing and the Administrator on 7/17/2020 at 4:30 PM, they were unable to provide evidence of an ongoing and comprehensive QAPI program.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** . Based on surveyor observation and staff interview, it has been determined that the facility failed to ensure a sanitary environment to help prevent the transmission of infections, including COVID-19, related to proper use of personal protective equipment (PPE) for 3 staff (Staff A, B, and C). Findings are as follows: Center for Disease Control and Prevention (CDC) document titled Responding to Coronavirus (COVID-19) in Nursing Homes updated on 4/30/2020 states in part, .All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e.(that is), goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown . An entrance interview on 9/29/2020 at 9:30 AM with the Director of Nursing (DNS) revealed there are currently 2 residents on a 14-day quarantine, Resident ID #'s 1 and 4. A surveyor obervation on 9/29/2020 at approximately 1:30 PM revealed the facility has an adequate supply of PPE, including N95 masks, gowns, gloves, and face shields. 1. Surveyor observation on 9/29/2020 at 8:47 AM revealed Staff A enter resident ID #1's quarantine room wearing only a surgical mask, which was not covering her nose, instead of an N95. No other PPE was worn upon entering the room. The staff member touched multiple items in the room, and then put on gloves and assisted the resident to transfer with her surgical mask, which was still pulled down under nose. During a surveyor interview on 9/29/2020, immediately following the above observation, Staff A acknowledged that she was not wearing the appropriate PPE in the room of the quarantined resident. 2. Surveyor observation on 9/29/2020 at approximately 8:50 AM revealed the Rehab Director (Staff B) in Resident ID #4's quarantine room, wearing a surgical mask, gown and gloves. No face shield, eye protection, or N95 mask were worn. During a surveyor interview on 9/29/2020 at 10:57 AM with Staff B, she acknowldeged that she was not wearing an N95 mask. She further acknowledged that Staff A was in a quarentine room and did not have on the appropriate PPE. 3. Surveyor observation on 9/29/2020 at 12:54 PM in the presence of the DNS, revealed Staff C in Resident ID #4's room wearing a surgical mask instead of an N95 mask and no eye protection or a face shield. During a surveyor interview on 9/29/2020 immediately after the above observation, Staff C acknowledged that she was not wearing the appropriate PPE when entering a 14-day quarentine room. During a surveyor interview on 9/29/2020 at 12:45 PM with the DNS, she could not explain why the staff were not following proper infection control practices when entering a 14-day quarentine room. Additionally, she revealed that the facility has a sufficient supply of PPE.