STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415038	A. BUILDING _____ B. WING _____	**06/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BANNISTER CTR FOR REHABILITATION AND HEALTH CARE	**135 DODGE STREET PROVIDENCE, RI 02907**

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 0584 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on surveyor observation and staff interview, it has been determined that the facility failed to provide a clean and sanitary environment and maintain housekeeping services relative to resident shower rooms on 1 of 3 units (second floor). Findings are as follows: Surveyor observation of the second floor shower room on 6/22/2020 at 11:20 AM revealed crumbled brown matter on the floor in front of the entrance to the toilet, used towels and personal laundry on the floor of the back left shower stall, and used wet towels in front of, and on top of a shower seat in the back right shower stall. Further observation revealed brown debris in the drains of 3 of 5 shower stalls. Additionally, 1 of 1 shower curtain was stained with orange matter (6 to 7 inches in length). During an observation and subsequent interview with a unit nurse, Staff E on 6/22/2020 at 11:25 AM, she acknowledged that the shower room was dirty. An interview with the second-floor housekeeper, Staff D on 6/22/2020 at 11:40 AM, revealed that he had not cleaned the second-floor shower room yet today. He also revealed that he worked on 6/21/2020 and did not clean the shower room. During an interview with the Housekeeping Director on 6/22/2020 at 12:35 PM, he acknowledged that the second-floor shower room was dirty. During an exit interview with the Regional Director on 6/22/2020 at approximately 2:20 PM, she acknowledged that the second-floor shower room was dirty and should have been cleaned.
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **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 provide services that meet accepted standards of professional practice relative to physician orders [REDACTED].#'s 2 and 17). Findings are as follows: Mosby's 4th Edition, Fundamentals of Nursing, states in part that, The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders [REDACTED]. 1. Record review revealed Resident ID # 2 has a physician's orders [REDACTED].=clear, V = Vesicular, D = Diminished, W = Wheezes, O = other Symptoms Key; Y/N (Yes or No) if any other symptoms, document in . . Record review failed to reveal documentation that lung sounds were obtained 22 of 22 opportunities between 6/8/2020 - 6/30/2020. 2. Record review revealed Resident ID # 17 has a medical history including but not limited to heart failure, pneumonia, and [MEDICAL CONDITION]. Record review revealed Resident ID #17 has a physician's orders [REDACTED].= clear, V = Vesicular, D = Diminished, W = Wheezes, O = other Symptoms Key; Y/N (Yes or No) if any other symptoms, document in PN (progress note) and notify . Record review failed to reveal documentation of lung sounds were obtained 10 of 11 opportunities between 5/23/2020 - 6/2/2020. During an interview on 6/30/2020 at approximately 2:00 PM, the Administrator was unable to produce evidence that the above physician's orders [REDACTED].
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 the facility failed to ensure that the resident environment remains as free of accident hazards as possible, and that residdents are provided with adequate supervision to prevent elopement for 1 of 10 sampled residents at high risk for elopement (ID #1). Findings are as follows: The facility's policy titled Elopement-Missing Resident, which was last revised in January 2020, states, in part, 3. Upon return of the resident to the facility, the Director of Nursing Services or Charge Nurse should: b. Contact the Attending Physician and report what happened; c. Contact the resident's legal representative (sponsor) and inform him/her of the incident . 4. f. Charge person to track times of events should include: 1. Time of event 2. Times of notification 3. Pertinent info to search 4. Time found . i. The charge person will notify the Executive Director, Director of Clinical Services and Police regarding the missing resident after the inside search is completed or within 10 minutes. 1. Facility to provide police with a photograph of resident to assist in the search j. Person in charge should coordinate communication / notification to resident's responsible party and attending physician . 6. Upon return of the resident to the facility, the Director of Nursing Services or Charge Nurse should . c. Contact the Attending Physician and report findings and conditions of the resident. Follow orders; d. Notify the resident's legal representative (sponsor); g. Make appropriate entries into the resident's medical record . 8. Notify appropriate state agencies as required. Resident ID #1 was admitted to the facility in February 2020 with [DIAGNOSES REDACTED]. (a disorder of the nerves/nervous system caused by vitamin B1 deficiency, typically from chronic alcoholism, and marked by mental confusion, abnormal eye movements, and unsteady walk). S/he was residing on the 4th floor, which is a locked unit in the facility; keypad entry is required for elevator access and the stairwells have a keypad to exit. If the stairwell is accessed without a keypad entry the door will alarm and open in 15 seconds. Review of the Minimum Data Set (MDS) assessment for Resident ID #1 dated 6/2/2020 revealed that the resident had severe cognitive impairment and was at high risk for elopement. Review of the elopement risk assessment dated [DATE] reveals the resident received a score of 24, which indicated s/he is at a high risk for elopement. Review of the elopement care plan dated 2/20/2020 includes an intervention of distracting the resident from wandering by offering pleasant diversions. Record review of the progress notes revealed the resident attempted to elope at least 5 times since his/her admission (3/8, 3/9, 3/10, 5/26), with the last attempt on 6/1/2020 being successful. On 6/3/2020 an anonymous complainant reported the incident of elopement by Resident ID #1, which occurred on 6/1/2020. This facility is in an urban setting within a short distance of 2 heavily traveled main streets. Record review revealed Resident ID #1 first attempted to elope on 6/1/2020 at approximately 4:07 PM but was unsuccessful. Record review further revealed the last time the resident was seen on the unit was between 4:22 PM, when s/he was medicated by Staff K, and 4:30 PM, when s/he was observed by Staff L. Record review of the staff statement from the Unit Nurse, Staff M (who no longer is employed by the facility), states in part . going round the building and attempting to open the exit door near (his/her) room. Resident was redirected many times by both CNA and the writer. At around 4:20 PM, resident was medicated by the CMT. At around 5:00 PM I heard from CNA assigned to resident that she was looking for Resident ID #1 . The surveyor conducted a telephone interview with the Security Officer, Staff N, on 6/26/2020 at approximately 1:25 PM. Staff N stated that he heard the audible alarm to the double doors (near the employee break room) which leads to the outside, indicating that the door had been opened without a security code. The wall monitor in the main office where he was stationed also indicated the door was alarming. In turn, he then reviewed the video monitor, which was on the desk, to view the double doors. He stated that he did not see anyone

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

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) attempting to leave the building. Next, he proceeded to check the three outside doors on the 1st floor. Eventually, he arrived at the door that had been alarming and found it to be slightly open. He acknowledged that he used the keypad to reset the door and that he did not initiate a Code Grey (the facility protocol to search for a missing resident) at that time nor did he notify supervisory staff. He further stated that approximately 5 minutes later Staff M asked if he had seen the resident. Staff N notified Staff M that he found the door to outside (staff breakroom) opened earlier and a Code Grey was initiated at that time. The surveyor interviewed the Administrator and the Director of Nursing (DON) on 6/26/2020 at 11:50 AM. The DON indicated that by the time staff responded to the 4th floor alarm door, they looked down the stairwell and did not see anyone. They then began searching the unit. After searching the unit, they realized who was missing and then staff began searching the area outside the building and across the street on foot. When the resident was not found by those on foot, the DON stated she began driving around the neighborhood looking for the resident and that she witnessed the police driving with their sirens on. She stated she followed the police which led her to the resident, who was being already evaluated by Emergency Medical Services (EMS), who were called by a bystander. The area where Resident ID #1 was located was at a busy intersection of two city streets about a mile away from the facility. The DON further stated that Resident ID #1 was bleeding from his/her mouth and had a laceration near his/her right eye area which occurred when s/he fell . The resident was subsequently transferred by ambulance to the hospital. Review of the hospital records requested by the surveyors indicated that the resident arrived at the emergency room at 6:01 PM. S/he was evaluated, a head CT scan (pictures of the brain and underneath the skull) was performed, and s/he received sutures for the eye area laceration. During surveyor interview with the resident's brother on 6/22/2020 at 11:12 AM, he revealed that the facility did not notify him or any family member that the resident had eloped, sustained an injury, or was transported to the hospital for evaluation. He stated that when he arrived to pick up Resident ID #1 for discharge the following day and asked about his/her cut near Resident ID #1's eye he was then told about the incident. During the initial entrance conference on 6/26/2020 at approximately 11:00 AM the surveyors along with the Administrator and DON toured the facility and reviewed the area of the elopement. At this time, it was discovered that the security guard can visually see that area on the video monitors but there is no sound. When someone presses on the outside door it softly beeps but not loud enough to hear the sound in the security office. Then if that person continues to egress the door for 15 seconds, that door will open and then a louder alarm will sound, and this triggers the wall monitor alarm at the security desk. The security desk from the door that the resident exited (staff breakroom) is approximately 30 feet away. It was also identified at this time that the facility was unable to provide video surveillance of this incident as it had been deleted. During a surveyor interview on 6/26/2020 at approximately 1:00 PM with the Administrator and DON they acknowledged that the facility did not notify the Department of Health of the elopement. The DON acknowledged that according to the review of the medical record, she could not provide evidence that the family or provider were notified of the elopement or emergency room visit. Neither the DON nor the Administrator could verify at what time the resident went missing, or how long the resident was missing for. The DON further acknowledged that the staff on the 4th floor did not respond appropriately to the audible stairwell alarm by thoroughly investigating the stairwell. The facility failed to ensure that the security protocol regarding responding to an alarm was followed. This resulted in a delay in locating Resident ID #1, a cognitively impaired resident, who was identified as high risk for elopement, from exiting the 4th floor locked unit stairway, travelling down 3 flights of stairs and exiting through another locked door. This delay and lack of supervision placed the resident in immediate jeopardy resulting in the resident falling and sustaining a laceration to the face requiring transfer to the hospital for sutures.
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, record review, and staff interview, it has been determined that the facility failed to ensure the staff utilized proper Personal Protective Equipment (PPE) and provided appropriate signage indicating precautions according to professional standards for 18 of 18 residents who are new admissions/readmissions on a 14-day quarantine (second floor). Findings are as follows: 1. The Center for Disease Control and Prevention (CDC) guidance 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 . During an entrance interview with the Assistant Director of Nursing (ADNS) on 6/22/2020 at approximately 8:20 AM, she revealed that the facility has placed all new admissions/readmissions on the second floor. They are on 14-day quarantine which consists of isolation precautions (measures that are intended to separate potentially infectious residents from others to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment). Surveyor observation of the second floor on 6/22/2020 at 10:48 AM revealed a staff member (Staff H) working on this unit wearing gloves and a surgical mask when providing care to Resident ID #5. She was not wearing a N95 mask, gown, or eye protection (goggles or face shield). During a surveyor interview on 6/22/2020 at 10:50 AM with a nursing assistant (Staff H), she revealed she is currently assigned to Resident ID #'s 4, 5, and 6 who are new admissions/readmissions on 14 day-quarantine with isolation precautions. She also revealed that when she is providing care to these residents, she only wears a surgical mask and gloves. During a surveyor interview with a staff nurse (Staff G) on 6/22/2020 at approximately 11:00 AM, she revealed that she is currently assigned to new admissions/readmissions residents who are on a 14-day quarantine with isolation precautions. She also revealed that when providing care to a quarantined room with isolation precautions, she only wears a surgical mask and gloves. During a surveyor interview on 6/22/2020 at 11:02 AM with the unit nurse (Staff F), she acknowledged that gowns and N95 masks should be worn while caring for residents who are new admissions/readmissions and on 14 day-quarantine with isolation precautions. During a subsequent surveyor observation on 6/22/2020 from 11:24 AM through 11:30 AM revealed an occupational therapy staff member (Staff C) providing care to Resident ID #3, without wearing a gown or face protection (goggles or face shield). A surveyor interview with the Director of Rehabilitation on 6/22/2020 at 1:00 PM revealed that the rehabilitation staff only wear a surgical mask and gloves while working with residents who are new admission/re-admission and on a 14-day quarantine with isolation precautions. Additionally, a surveyor observation on 6/22/2020 between 10:40 AM and 11:45 AM revealed a housekeeper (Staff D) wearing his surgical mask incorrectly, not covering his nose and at times not covering neither his nose nor mouth. During a subsequent interview with Staff D, he acknowledged that he was not wearing his surgical mask correctly while working. An additional surveyor observation on 6/22/2020 at approximately 11:00 AM revealed unit nurse (Staff F) wearing her surgical mask incorrectly, not covering her nose while working. During an exit interview on 6/22/2020 at approximately 2:15 PM with the Regional Director, she acknowledged that staff working with the 14-day quarantined residents are only wearing a surgical mask and gloves when providing care to these residents. 2. The Center for Disease Control and Prevention (CDC) guidance titled Responding to Coronavirus (COVID-19) in Nursing Homes (last reviewed 4/30/2020) states, in part, .Place signage at the entrance to the COVID-19 care unit that instructs HCP (healthcare professionals) they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit . During an entrance interview with the Assistant Director of Nursing (ADNS) on 6/22/2020 at approximately 8:20 AM, the residents on the second floor are admissions/readmissions to the facility and placed on a 14-day quarantine which consists of isolation precautions. Surveyor observation of the quarantine room door frames on 6/22/2020 between 10:35 AM and 11:05 AM revealed only Resident ID #'s 5 and 6 doors had signage that read, STOP, contact nurse before entering posted outside of their respective doorways. There were no signs outside of any room on the second floor indicating the type of precautions and PPE required before entering. During an interview with a nursing assistant, Staff H on 6/22/2020 at 10:50 AM, she revealed that she did not know which residents were on isolation precautions based on the signage outside of Resident ID #'s 4, 5, and 6 rooms. During a staff interview with the charge nurse, Staff F on 6/22/2020 at approximately 11:00 AM revealed that all residents on the second floor currently are on isolation precautions that require use of PPE. During an exit interview on 6/22/2020 at approximately 2:20 PM with the Regional Director, she acknowledged that all newly admitted /readmitted residents on 14-day quarantine should have precaution signage posted outside of their rooms, indicating the residents are on isolation precautions.