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 _____	08/21/2020

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 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **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 maintain acceptable parameters of nutritional status, such as usual body weight for 2 of 3 sample residents reviewed (Resident ID's #1 and #5). Findings are as follows: 1. Record review for Resident ID #1 revealed an admitted [DATE] with [DIAGNOSES REDACTED]. Review of the weight documentation revealed the following: -6/24/2020: 88 lbs -6/25/2020: 85 lbs Review of the Dietary Nutrition Assessment note, dated 6/21/2020, revealed that the resident's ideal body weight is between 140 pounds (lbs) - 169 lbs. The note indicates Food intake: 50% or less The resident is refusing food . Further review of the above Dietary Nutrition Assessment note revealed a recommendation for High Cal (high-calorie oral supplement fortified with vitamins and minerals), 4 ounces, twice daily. Record review revealed Resident ID #1 has a physician's orders [REDACTED]. Review of the Treatment Administration Record failed to reveal evidence that the High Cal was given between 6/25 - 6/29/2020. Further record review failed to reveal that the Dietitian was notified when the resident had not received the High Cal. Additional record review of the meal consumption record between 6/25 and 6/29/2020 revealed that the resident consumed 0 - 50% for 9 out of the 13 meals served. Further record review revealed that on 6/29/2020, the resident was noted with lethargy and s/he was sent to the hospital for an evaluation. The resident was later admitted to the Intensive Care Unit. During an interview with the Director of Nurses (DNS) on 07/29/2020 at 2:30 PM. She stated the High Cal was discontinued because we did not have it at the time. During a phone interview with the Dietitian on 7/29/2020 at 3:00 PM, she revealed the High Cal supplement was recommended due to the resident's poor intake. She stated that she was not aware that the High Cal was unavailable and not given between 6/25 - 6/29/2020. She stated she would have recommended other nutritional supplements such as Ensure, Ensure Plus or Ensure Clear if the High Cal was not available. During an interview with the DNS and the Regional Nurse on 7/30/2020 at 2:00 PM, the DNS was unable to provide evidence that another intervention was added to address the nutritional needs of Resident ID #1. 2. The facility's policy for Weight Assessment and Interventions revised on 5/2019 states in part, a. Any weight change . and 3 lbs (pounds) in a week since their last weight assessment will be retaken within 48 hours for confirmation and verified by Nursing. b. Re weigh should be reviewed by the Licensed Nurse. c. Licensed Nurse will notify Dietician of identified weight change once reviewed d. Dietician notification should be documented within Resident's medical record e. Dietitian or diet technician will respond within 72 hours of receipt of notification . Record review for Resident ID #5 revealed the resident was readmitted in July 2020. Review of the resident's weights revealed the following: - 7/20/20 weight 151 lb - 7/21/20 weight 154 lb - 7/22/20 weight 150.9 lb - 7/29/20 weight 146.2 lb (decreased 4.7 lbs from 7/22/2020) - 8/5/2020 weight 142.2 lbs (decrease 8.7 lbs from 7/22/2020). Record review lacked evidence that the resident's weight was retaken after the resident lost more than 3 pounds from 7/22 - 7/29/2020. Additionally, the clinical record failed to reveal evidence that the nurse notified the Dietitian of the weight change or that the Dietitian documented the notification in the resident's clinical record. During the interview with the DNS on 08/05/2020 at 1:40 PM she was unable to provide evidence that the resident's weight was retaken within 48 hours after the resident lost more than 3 pounds, per the facility policy. The DNS was also unable to provide evidence that the Dietitian documented the notification in the resident's record.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** Based on record review and staff interview, it has been determined that the facility failed to maintain clinical records on each resident in accordance with acceptable professional standards and practice that are complete and accurately documented for 1 of 3 sampled residents reviewed, Resident ID #1. Findings are as follows: 1. Record review for Resident ID #1 revealed the resident was admitted to the facility with an indwelling Foley catheter (a tube which is inserted into the bladder and left in place for draining urine). The record lacked evidence of when/if the foley catheter was removed. As evidenced by the following: -Staff documented that the resident is continent of bladder during the 11:00 PM - 7:00 AM shift on 6/19, 6/22, 6/23, 6/24, 6/25, 6/26, 6/28 and 6/29, during 3:00 PM - 11:00 PM shifts on 6/19, 6/22 and 6/29 and during 3:00 PM - 11:00 PM on 6/15, 6/19 and 6/28/2020. -Staff documented that the resident is incontinent of bladder during the 3:00 PM - 11:00 PM shifts on 6/16, 6/18, 6/20, 6/21, 6/22, 6/24, and during 7:00 AM - 3:00 PM on 6/15, 6/16, 6/18, 6/20, and 6/22/2020. -Staff documented that Continence Not Rated due to Condom Catheter during the 7:00 AM - 3:00 PM shift on 6/17, 6/21, 6/23, 6/24, 6/25, 6/26. 6/27, 6/28 and 6/29/2020. During an interview with the Director of Nursing Services (DNS) on 7/30/2020 at approximately 2:00 PM, the DNS stated the resident was admitted with the Foley catheter but she was not sure if the catheter was discontinued or not. The DNS further stated Resident ID #1 did not have the Condom catheter and acknowledged staff did not accurately documented Resident ID #1's condition.
F 0880 **Level of harm** - Immediate jeopardy **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 properly prevent and contain the potential spread and transmission of COVID-19 relative to personal protective equipment (PPE) and failure to follow isolation guidance. Findings are as follows: 1. The Center for Medicare and Medicaid Services (CMS) released a memo on 5/18/2020 for Nursing Home Reopening Recommendations for State and Local Officials which states in part, Nursing homes have been severely impacted by COVID-19, with outbreaks casing high rate of infection, morbidity, and mortality. The vulnerable nature of the nursing home population ., requires aggressive efforts to limit COVID-19 exposure and to prevent the spread of COVID-19 within nursing homes . Universal source control for everyone in the facility wear cloth face covering or facemask .All staff wear appropriate PPE when they are interacting with residents, . During a surveyor interview on 7/30/2020 at approximately 1:00 PM, the Director of Nursing Services (DNS) stated there are approximately 36 residents who tested positive for COVID-19 in the facility. Surveyor observation on 7/30/2020 between 1:00 PM and 1:45 PM and 8/4/2020 between 10:00 AM and 11:30 AM revealed the following: - Staff A was observed not wearing a face mask. He was observed entering the elevator where there was another staff member. - Staff B was observed sitting in the main dining room. She was observed wearing a face mask under her chin. Her face mask did not cover her mouth or her nose. There were 3 other staff members standing in the room (less than 6 feet apart from her). Additional surveyor observation approximately 20 minutes later, revealed Staff B sitting at the 4th floor nursing station. Her face mask was again observed on her chin and it did not cover her mouth or nose. There was another staff member sitting at the nursing station (less than 6 feet apart from her). - Staff C was observed in the main dining room wearing a face mask but the face

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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) mask did not cover her mouth or her nose. There were 2 other staff members that were in the dining room (less than unless 6 feet apart from her). During an interview with the Regional Nurse and the DNS on 7/30/2020 at approximately 2:00 PM, the DNS stated all staff are given masks upon entering the building and they are expected to wear their masks. 2. The Center for Disease Control and Prevention's guidance, titled Preparing for COVID-19 in Nursing Homes (last updated 6/25/2020), states in part: Residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of . eye protection (i.e., goggles or a face shield that covers the front and sides of the face) . Surveyor observation, in the presence of the DNS, on 08/04/2020 at approximately 11:15 AM revealed Staff D not wearing eye protection going into a COVID-19 positive resident's room (Resident ID #6) to administer medications. During an interview with Staff D, immediately following the observation, she stated she did not have eye protection wear. Staff D acknowledged that she should be wearing the eye protection going into a COVID-19 positive resident's room . When questioned about eye protection, the DNS stated all nursing staff are given eye protection, and instructed to wear it when providing care to COVID-19 positive residents. 3. The Rhode Island Department of Health (RIDOH) Coronavirus Disease 2019 (COVID-19) Quarantine and Isolation Guidance by Population updated on July 23, 2020 states in part . Symptomatic person isolate for at least 10 days until: - At least 10 days have passed since symptoms first appeared . Asymptomatic person, tested positive and does not have symptoms - Isolation may be discontinued when at least 10 days have passed since the date of their first positive diagnostic test . Work During Isolation? Yes, in limited circumstances (healthcare staff only) and in consultation with RIDOH: - If needed to fill a critical staffing position . Record review of the COVID-19 staff line list on 08/04/2020 revealed that Staff E was tested positive for COVID-19 on 07/23/2020. Review of a signed statement from Human Resources, dated 8/4/2020, revealed that Staff E returned to work on 07/30/2020, which is only 7 days since his first positive diagnosis. During a surveyor interview with the DNS on 08/04/2020 at 2:00 PM, the DNS confirmed that Staff E returned to work on 07/30/2020. 4. During surveyor observation of the second-floor unit on 8/19/2020 from approximately 11:00-11:08 AM, housekeeping staff, Staff F, was noted to be in a COVID-19 positive resident's room, wearing an N-95 Mask and gloves, the door was noted to be open. He exited the room (without washing his hands or changing his gloves) and retrieved a bottle of a cleaning agent from the housekeeping cart which was located against the opposite wall of the hallway and went back into room. He again exited the room (without washing his hands or changing his gloves) and proceeded to walk down the hall, approximately 50 feet, to the clean utility room. He entered the room by opening the door by the handle with his gloved hand. He exited the clean utility room and proceeded back down the hall and returned to the COVID-19 positive resident's room, closing the door behind him. He was observed exiting via the door of the adjoining room, of a resident that is COVID-19 negative, and returned to the housekeeping cart. During a surveyor interview with Staff F, which took place upon exiting the room and returning to his housekeeping cart, on 8/19/2020, he acknowledged the occurrences stated above, causing a breach in infection control practices. 5. During surveyor observation on 8/19/2020 at 11:21 AM of the fourth floor unit revealed nursing assistant, Staff H, remove her PPE in the doorway of Resident ID # 9's room, a COVID-19 positive room. After removing her gloves and gown, she was then observed removing her face shield and placing the contaminated face shield on top of the clean laundry cart which was just outside the room. Staff H was then observed exiting the resident's room with a full trash bag, walking through the hallway, traveling approximately 50 feet to the soiled utility room. She then exited the soiled utility room and walked back down the hallway to the shower room, which is directly across from that same resident's room, where she was then observed washing her hands. Staff H then removed her goggles, and then retrieved her contaminated face shield off the clean linen cart. She then went to nurse's station where she was observed putting her goggles and face shield in a plastic shopping bag. Staff H was not observed disinfecting the clean utility cart During a surveyor interview on 8/19/2020 at 11:26 AM with Staff H revealed she went to get a disinfectant cloth from the nurse and then wiped down the face shield and goggles after she had put the face shield on the cart. 6. During surveyor observation on 8/19/2020 at 10:10 AM of the third floor unit revealed a nursing assistant, Staff G, exiting Resident ID # 7's room with a face shield and two masks on (surgical over the KN 95). Subsequently, she was observed entering two different resident rooms and conversing with residents in their rooms, within 2-3 feet apart, without changing surgical masks between each resident. During a surveyor interview with Staff G on 8/19/2020 at 11:15 AM, she stated she was in Resident ID # 7's room for am care. She stated she removed her gown and gloves, then washed her hands in that resident's bathroom. She then disinfected her face shield with alcohol gel in that resident's bathroom. During a surveyor interview with the DNS on 8/19/2020 at approximately 12:00 PM, she stated, staff should be donning and doffing their PPE at the resident's doorway, taking off their PPE upon exiting the room and cleansing the face shield at the door before exiting. This facility has had a total of 95 cases since the beginning of the pandemic. The positive cases involved 29 staff members and 66 residents. The facility cases have been part of two outbreaks. The following numbers only include first-time positives, not greater than a 3-month span of positive cases. The first outbreak was noted in April of 2020 which included 10 positive staff members with 1 fatality and 6 positive resident cases with 0 fatalities. The facility is currently in their second outbreak, which began on 7/3/2020, and as of today, 8/21/2020, there have been 19 positive cases involving staff members with 0 fatalities and 60 positive cases involving residents with 7 fatalities. Initially, the second outbreak was contained mostly to the third floor unit involving residents, their cases have now spread to the second and fourth floor units resulting in the totals for each floor as listed below: Unknown unit = 3 residents Second floor unit = 9 residents Third floor unit = 40 residents Fourth floor unit = 8 residents