STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415052	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHARLESGATE NURSING CENTER	**100 RANDALL STREET PROVIDENCE, RI 02904**

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 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, record review and staff interviews, it has been determined that the facility failed to ensure a resident with limited range of motion receives appropriate treatment to prevent further decline in range of motion for 1 of 1 resident reviewed (ID #100). Findings are as follows: Record review revealed that Resident ID #100 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further record review revealed the following physician's orders [REDACTED]. 8/13/2019 Staff to place on left UE (upper extremity) Elbow ext splint after lunch and supper . Review of the care plan in place for Activity of Daily Living revealed intervention dated 8/23/2019 stating in part, Pt to wear Left hand splint every morning after care to help with contraction management . and Staff to place on left UE Elbow ext splint after lunch . Surveyor observation on the following dates and times revealed the resident without a left-hand splint and left elbow splint on his/her hand or elbow: 3/3/2020: 9:09 AM, 10:11 AM, 12:10 PM, 1:35 PM 3/4/2020: 8:51 AM, 9:16 AM, 10:59 AM, 1:24 PM, 2:06 PM 3/5/2020: 8:11 AM, 8:53 AM During a surveyor interview on 3/5/2020 at 8:53 AM with the Certified Nursing Assistant (CNA) Staff B, she revealed that she was not aware of the orders and had not applied the left-hand splint or left elbow splint to the resident hand or elbow. During a surveyor interview on 3/5/2020 at 9:21 AM with the unit nurse, Staff A, she acknowledged that the resident was not wearing the left-hand and left elbow splints.
F 0710 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.** **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 the medical care of each resident is supervised by a physician for 1 of 2 residents relative to recommendation from an outside consultant (ID #154). Findings are as follows: Resident ID #154 was admitted to the facility in February 2020 with [DIAGNOSES REDACTED]. Review of an Admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status score of 15 out of 15, indicating the resident is cognitively intact. Review of Wound Evaluation and Management Summary reports dated 2/19/2020 and 2/26/2020, revealed in part: .Recommendations: off-load wound; elevate leg(s); and float heels in bed . The reports also revealed that the patient's care was discussed with a nursing staff member during these visits. Review of the resident's care plan revealed an intervention initiated on 2/28/2020 stating Treat ulcer: as ordered by wound MD. Review of the clinical record failed to reveal evidence of orders put in place for the above recommendations or that the recommendations were addressed by the resident's attending physician. During a surveyor observation of Resident ID #154 on 3/06/2020 at 10:47 AM, s/he was observed in his/her room sleeping in bed and his/her legs were not elevated and heels were not floated. A surveyor interview was conducted on 3/05/2020 at 3:01 PM with the resident. S/he revealed that no one has told him/her to elevate his/her legs, and staff do not put anything under his/her legs or feet when s/he is in bed. During a surveyor interview on 3/05/2020 at 3:26 PM with Certified Nursing Assistant, Staff C, she revealed that Resident ID #154 is known to her. She further revealed that the resident does not need anything special done for him/her when s/he is in bed, and nothing is put under the resident's legs or feet when s/he is in bed. During a surveyor interview on 3/06/2020 at 12:09 PM with the Director of Nursing Services, she was unable to provide evidence of orders for the above recommendations, or evidence that the orders were addressed by the resident's physician.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it has been determined the facility failed to ensure a resident's drug regimen review was reviewed and/or acted upon by the attending Physician after irregularities were noted for 1 of 7 sampled residents reviewed for monthly pharmacy drug regimen reviews (ID #40). Findings are as follows: 1. Clinical record review for Resident ID #40 revealed current physician's orders [REDACTED]. A review of the pharmacist medication regimen review revealed a recommendation dated 2/14/2020 that stated, Please consider discontinuing aspirin until [MEDICATION NAME] is no longer needed. If concomitant therapy is to continue, it is recommended that: (a) the prescriber document an assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual . Record review lacked evidence of documentation that the recommendation was reviewed by the physician. During a surveyor interview with the Director of Nursing Services on 03/06/2020 at 11:51 AM, she was unable to provide evidence that the drug regimen review was acted upon or reviewed by the attending physician.
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.** **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 maintain clinical record on each resident in accordance with acceptable professional standards and practice that are complete and accurately documented for 1 of 1 sample resident (ID #100). Findings are as follows: Review of Resident ID #100's clinical record revealed physician's orders [REDACTED]. and Staff to place on left UE (upper extremity) ext splint after lunch . Review of the Medication Administration Record [REDACTED]. During an interview on 3/5/2020 at 9:21 AM with unit nurse Staff A, she acknowledged that she did not apply both splints and could not explain why she signed off orders that had not been completed. During an interview on 3/5/2020 at 10:00 AM with the Director of Nursing Services, she acknowledged that orders should be signed off by nurses after completing a task and if a task was not completed the orders should not be signed off.

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.