

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2023
NAME OF PROVIDER OR SUPPLIER Elmhurst Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 50 Maude Street Providence, RI 02908	

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)
<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>39496</p> <p>47939</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure a physician reviewed the resident's total program of care, including medications and treatments, at each visit, for 1 of 5 residents reviewed, Resident ID #147.</p> <p>Findings are as follows:</p> <p>Record review revealed that Resident ID #147 was readmitted to the facility in February of 2023 and has diagnoses including, but not limited to, chronic kidney disease stage 4 (when your kidneys can no longer support your body's needs), dependence on renal dialysis, and acute on chronic diastolic (congestive) heart failure.</p> <p>Review of an order received by a covering Physician (from a contracted provider) dated 2/24/2023 at 8:56 PM, revealed in part, .orders and medications approved until patient is evaluated by primary team. Obtain and review all acute care documentation/orders with primary team when available .Daily weights. Low sodium diet. 2 Liter Fluid Restriction .Recommend that primary team review medication and eliminate unnecessary medications . The order was signed by the Physician on 2/24/2023 at 9:04 PM.</p> <p>Review of the resident's orders failed to reveal that the orders for daily weights and a 2 liter fluid restriction were implemented or discontinued.</p> <p>Review of the Medication Administration/Treatment Administration Record failed to reveal that the above orders were implemented.</p> <p>Record review of the Weights and Vitals summary failed to reveal that daily weights were obtained.</p> <p>Review of a History & Physical note dated 2/25/2023 at 2:03 PM by the resident's attending physician revealed in part, .Pt is seen today for an initial visit and management of medical conditions .Assessment and Plan .ESRD [end stage renal disease] on HD [hemodialysis] .Chronic HF [heart failure] .Cont [continue] diuretics .on non HD days. Fluid restriction. Follow daily wts. [weights] .</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of progress notes signed on 3/7/2023 at 9:17 PM, and 3/15/2023 at 10:02 PM and 12:02 AM by Nurse Practitioner, Staff F, revealed in part, .Assessment and Plan .continue present diuretics. Follow daily weights .Chronic kidney disease .Encourage fluids .</p> <p>During a surveyor telephone interview on 3/21/2023 at approximately 10:30 AM with the attending physician, he could not explain why the covering physician's order for fluid restriction was not transcribed or why his note indicated a fluid restriction and daily weights were in place when they were not.</p> <p>During a surveyor interview on 3/21/2023 at 12:18 PM with Nurse Practitioner, Staff F, she could not explain why her notes dated 3/7 and 3/15/2023 indicated that the resident was on daily weights when s/he was not.</p> <p>During a surveyor interview on 3/22/2023 at approximately 2:00 PM with the Director of Nursing Services and the Administrator, they were unable to provide evidence that the physician and [Nurse Practitioner] reviewed the resident's total program of care. When asked if it was expected that a physician's note would accurately reflect the current plan of care for the resident, they acknowledged that they would.</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>46715</p> <p>Based on record review and staff interview it has been determined that the facility failed to ensure that its residents are kept free from significant medication errors for 1 of 1 residents reviewed for ear drops, Resident ID #150, 1 of 4 residents reviewed for antibiotic use, Resident ID #176 and 1 of 8 residents reviewed for hospitalization and medication reconciliation, Resident ID #291.</p> <p>Findings are as follows:</p> <p>1. Review of a facility policy titled, Administering Medication states in part, Medications are administered in a safe and timely manner, and as prescribed .</p> <p>Record review revealed Resident ID #150 was admitted to the facility in May of 2022 with diagnoses including, but not limited to, Alzheimer's disease and hearing loss.</p> <p>Review of a complaint received by the Rhode Island Department of Health on 3/10/2023 alleges in part, On 3/7/23 while visiting .a nurse came in to give nightly meds [medication] and ear drops. The nurse put the ear drops in [his/her] eyes. [The resident] immediately began to scream that it hurt .I yelled stop, are those [his/her] ear drops, she stopped and looked at me .I put a cold face cloth on [the resident's] eye and waited for help .</p> <p>Record review revealed the resident had an order for Debrox Solution 6.5% (Carbamide Peroxide, a medication used to treat earwax buildup) Instill 5 drops in both ears two times a day for hearing loss.</p> <p>Record review of the Medication Administration Record (MAR) for March 2023 indicated the medication was signed off as administered on 3/7/2023 by Registered Nurse (RN), Staff J.</p> <p>Review of a progress note dated 3/7/2023 at 8:24 PM revealed a telehealth note that stated in part, . complaining of left eye irritation after accidental administration of carbide peroxide otic gtt [ear drops] was instilled in eye. Eye is irritated.</p> <p>Review of a progress note dated 3/7/2023 at 11:43 PM revealed that a nurse had made a medication error and administered ear drops in the left eye instead of the left ear. The progress note further revealed that the resident was in pain following the administration of the ear drops into the left eye and it was flushed with sterile water and a syringe.</p> <p>Review of a progress note dated 3/8/2023 at 8:00 AM revealed the resident's left eye remained red.</p> <p>During a surveyor interview on 3/13/2023 at 12:14 PM with the resident's family member she revealed that she was visiting the resident on 3/7/2023 and witnessed a nurse administer ear drops into the resident's left eye. Additionally, she revealed the resident was screaming in pain and shaking following the medication administration. The resident's family revealed that she applied a cold compress to the resident's left eye and it took the staff greater than 10 minutes to return to the room.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>During a surveyor interview on 3/13/2023 at 1:47 PM with Staff J she acknowledged that she administered the medication prescribed for the ears into the resident's left eye. Additionally, she revealed the resident was yelling, stop that hurts. She further revealed that she immediately left the room and did not return.</p> <p>During a surveyor interview on 3/13/2023 at 1:57 PM with Licensed Practical Nurse (LPN), Staff K he revealed that he was the nurse working with Staff J and that they prepared the medication outside of the room and that he was not present when she administered the medication incorrectly but that she reported it to him. Additionally, he revealed the resident was in pain when he entered the room and was complaining there is something in his/her eye.</p> <p>Record review revealed an order dated 3/7/2023 for prednisoLONE Acetate Ophthalmic Suspension 1% (a medication used to treat certain eye conditions due to inflammation or injury) Instill 1 drop in left eye two times a day for Irritation.</p> <p>During a surveyor interview with two surveyors on 3/14/2023 at 1:54 PM with the Director of Nursing Services in the presence of the Administrator they acknowledged that the medication error had occurred.</p> <p>2. Record review revealed Resident ID #176 was admitted to the facility in January of 2023 with diagnoses including, but not limited to, bacteremia (the presence of bacteria in the blood) and osteomyelitis (an infection of the bone) of the spine.</p> <p>Record review revealed a Continuity of Care Consultation and Referral Form dated 3/7/2023 from the Infectious Disease Nurse Practitioner [specialist that treats infections disease] that states in part, continue levofloxacin [antibiotic] 750 daily .call regarding end date of antibiotics .</p> <p>Review of the MAR for February 2023 revealed an order for Levofloxacin 750 mg (milligrams) with the last administration dated 2/21/2023.</p> <p>Review of the MAR for March 2023 failed to reveal evidence that the resident was administered Levofloxacin.</p> <p>During a surveyor interview on 3/8/2023 at 11:02 AM with the Infectious Disease Nurse Practitioner he revealed that the resident was last seen at his office on 2/21/2023 and the resident was to continue taking the Levofloxacin 750 mg from 2/21/2023 until 3/8/2023. Additionally, he revealed that he was unaware the resident had not received the antibiotic as ordered from 2/22/2023 until 3/8/2023 which was brought to his attention by the surveyor.</p> <p>During a surveyor interview on 3/9/2023 at 8:47 AM with Unit Manager, Registered Nurse, Staff E she acknowledged that the resident was not on the antibiotic from 2/22/2023 until 3/8/2023 as ordered by Infectious Disease Nurse Practitioner.</p> <p>During a surveyor interview with two surveyors present on 3/10/2023 at 11:39 AM with the Director of Nursing Services she was unable to provide evidence that the resident received the Levofloxacin as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>3. Record review revealed that Resident ID #291 was admitted to the facility in March of 2023 and has diagnoses including, but not limited to, acute respiratory failure with hypoxia (when your lungs cannot release enough oxygen into your blood, which prevents your organs from properly functioning) and end stage renal disease (when your kidneys can no longer support your body's needs).</p> <p>Additional record review reveals this resident receives hemodialysis (a type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to) three times a week.</p> <p>Review of a hospital discharge summary dated 3/1/2023 revealed Further review of the hospital Discharge Summary states in part, Discharge Medication Current Discharge Medication List .CONTINUE these medications which have NOT CHANGED .albuterol [is used to treat wheezing and shortness of breath caused by breathing problems] .90 mcg [micrograms] .inhaler inhale 2 (two) puffs by mouth every 6 (six) hours.</p> <p>Record review of the March 2023 MAR revealed an order dated 3/1/2023 which states in part, ,(Albuterol Sulfate) 2 puff inhale orally every 12 hours as needed for SOB [shortness of breath] separate puffs by at least 1 minute.</p> <p>Further record review failed to reveal evidence that the resident's albuterol was transcribed as ordered per the Discharge Summary or that the physician at the facility modified the order. This indicates the resident did not receive his/her ordered inhaler for approximately 20 out of 22 opportunities, as s/he received two as needed doses on 3/6/2023 at 5:32 AM and 3/8/2023 at 6:10 AM.</p> <p>Additional record review of the March 2023 MAR revealed that on 3/3/2023 the resident was not administered the following medications:</p> <ol style="list-style-type: none"> 1. Alogliptin Benzoate tablet 6.25 MG (Milligram), medication for diabetes 2. amlodipine Besylate tablet 10 MG, medication for hypertension 3. Aspirin tablet 81 MG, medication used as a preventive for blood clots 4. Bactrim DS tablet 800-160 MG, antibiotic medication 5. Calcitriol capsule 0.25 MG, calcium supplement 6. Ferrous Sulfate tablet 325 MG, iron supplement 7. GlycoLax Powder 17 Gram, Medication used for constipation 8. Isosorbide Mononitrate ER tablet 60 MG, medication used to prevent chest pain 9. Ompersazole DR 20 MG Capsule, medication used heartburn 10. PrediSONE tablet 20 MG used for respiratory failure 11. Semglee (insulin) 26 Units medication for diabetes <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>12. Sertraline Tablet 100 MG medication used for depression</p> <p>13. Toprol XL Oral Tablet 60 Mg medication used to treat chest pain, heart failure, and high blood pressure</p> <p>14. Icosapent Ethyl Capsule 1 gram, medication used for cholesterol</p> <p>15. hydrALAZINE HCl Oral Tablet 50 MG used to treat hypertension</p> <p>16. NovoLOG Injection Solution medication to help with high blood sugar</p> <p>During a surveyor interview in the presence of an additional surveyor on 3/15/2023 at 10:41 AM with Unit Manager, Registered Nurse, Staff E, she was unable to provide evidence the Albuterol was administered to the resident every six hours as ordered. Additionally, she was unable to provide evidence that the Nurse Practitioner (NP), Staff F, was notified of the missed doses of the above-mentioned medications on 3/3/2023.</p> <p>During a surveyor interview in the presence of an additional surveyor on 3/14/2023 at 2:43 PM with Staff F she revealed that she would have implemented the discharge orders from the hospital including the orders for standing albuterol. Additionally, she revealed she would expect to be notified when a resident misses their scheduled medication.</p> <p>During a surveyor interview in the presence of an additional surveyor on 3/14/2023 at approximately 2:00 PM with the Director of Nursing Services and the Regional Nurse, they were unable to provide evidence that the resident's albuterol inhaler was implemented per the discharge summary. Additionally, she was unable to provide evidence the NP or physician were notified the resident missed the previously mentioned medications on 3/3/2023.</p> <p>46539</p>