RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01502	A. BUILDING: _____ B. WING _____	05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD WOODS	171 PLEASANT VIEW AVENUE SMITHFIELD, RI 02917

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S 003	Initial Comments An unannounced biennial State Licensure survey and a complaint/incident investigation survey (ILP111, 05/01/2023) were conducted at this residence. Deficiencies were identified relative to the State Licensure survey.	S 003	The filing of this plan of correction does not constitute an admission of the allegations set forth in this statement of deficiencies. This plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law. RECEIVED JUN 16 2023 CILITIES REGULATION	6/23/23
S 075	Licensure Requirements 2.4.5(A) Safe Resident Handling 2.4.5 (A) Safe Resident Handling A. Each licensed assisted living residence with an "Alzheimer ' s Dementia Special Care Unit or Program" license and/or offers to provide or provides coordination of hospice services for residents who are bed-bound or in need of assistance from more than one staff person for ambulation shall comply with the provisions of §§ 2.4.5(B) through (E) of this Part as a condition of licensure. 1. Notwithstanding the requirements of § 2.4.5(A) of this Part, assisted living residences licensed for an "Alzheimer ' s Dementia Special Care Unit or Program" prior to 1 June 2015 shall be in compliance with the requirements of §§ 2.4.5(B) through (E) of this Part not later than 1 July 2015. 2. A currently licensed assisted living residence who applies for a new level of licensure on or after 1 June 2015 will be required to meet the requirements of §§ 2.4.5(B) through (E) of this Part prior to a new license level being approved. This Requirement is not met as evidenced by: Based on record review and staff interview, the residence with an "Alzheimer's Dementia Special Care Unit or Program" license failed to ensure there was a Safe Resident Handling program which complies with the provisions of §§ 2.4.5(B)	S 075 6/10/23	Safe resident meeting held 5/24/23. Policy reviewed and calendar created for the year. Safe resident handling assessment will be completed on all Memory Care residents with each 90 day nurse review. Audit to be completed by 6/9/23 of all Memory Care residents to ensure safe resident handling assessments are completed. 10% of Memory Care residents will be audited to ensure safe resident handing assessment has been completed quarterly x12 months. Safe resident handling meeting minutes and safe resident handling assessments will be reviewed quarterly in QA for compliance x12 months.	

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brittany Hemsley	area	6/2/23

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S 075	Continued From page 1 through (E) as a condition of licensure. Findings are as follows: The residence failed to produce evidence there was an established Safe Resident Handling program which included the following components: - Maintain a safe resident handling committee, chaired by a professional nurse or other appropriate licensed health care professional with at least half of the members of the committee being hourly, non-managerial employees who provide direct resident care - A written safe resident handling program, with input from the safe handling committee, to prevent musculoskeletal disorders among health care workers and injuries to residents During an interview on 04/28/2023 at approximately 1:00 PM, the Executive Director was unable to provide evidence of a Safe Resident Handling program or committee.	S 075		
S 190	Organization And Management 2.4.12(H) Administrative Management 2.4.12 (H) In-service Training 1. Employees shall have on-going, at intervals not to exceed twelve (12) months, in-service training as appropriate for their job classifications and including the topics cited in § 2.4.12(G) of this Part. 2. All new employee orientation and on-going in-service training shall be documented in the	S 190		

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S 190	Continued From page 2 employee's personnel file, and maintained onsite at the licensed residence. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined the residence failed to ensure that newly hired staff received in-servicing training within ten (10) days of hire and prior to beginning work alone and existing staff received on-going, at intervals not to exceed twelve (12) months, in-service training for six of six sample employees, Staff A,B,C,D,E and F. Findings are as follows: 1) Record review of Staff A revealed a hire date of 03/15/2023. This employee was hired as a Registered Nurse/Director of Wellness. 2) Record review for Staff B revealed a hire date of 01/11/2023. This employee was hired as a Certified Nursing Assistant (CNA). 3) Record review for Staff C revealed a hire date of 09/20/2022. This employee was hired as a CNA. 4) Record review for Staff D revealed a hire date of 01/04/2021. This employee was hired as a CNA. 5) Record review for Staff E revealed a hire date of 02/25/2022. This employee was hired as Certified Medication Technician (CMT)/CNA. 6) Record review for Staff F revealed a hire date of 04/06/2022. This employee was hired as a CMT/CNA.	S 190	Staff A-F will receive and sign off on new hire orientation as regulated by 6/9/23. Audit of all active staff will be completed by 6/16/23 on completion of new hire orientation to ensure compliance. Internal transcript from training system to be implemented to ensure compliance. BOM or designee will audit new hire orientation weekly x4 weeks, then monthly x6 months. Audits will be reviewed in QA x6 months to ensure compliance. 6/16/23	

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S 190	Continued From page 3 Record review failed to reveal evidence that the above employees had received all required in-service training in the following areas prior to working alone: a. Fire prevention; b. Recognition and reporting of abuse, neglect, and mistreatment; c. Assisted living philosophy (goals/values: dignity, independence, autonomy, choice); d. Resident's rights; e. Confidentiality; f. Emergency preparedness and procedures; g. Medical emergency procedures; h. Infection control policies and procedures; i. Resident elopement; j. Basic sanitation; k. Food service; l. Basic knowledge of cultural differences; m. Basic knowledge of aging-related behaviors including dementia and Alzheimer's disease; n. Personal assistance; o. Assistance with medications; p. Safety of residents; q. Body Mechanics; i. Resident Transfers (required for residences licensed at the F1 level for fire safety); j. Record-keeping; k. Service plans; and l. Internal reporting. During an interview on 04/28/2023 at approximately 3:45 PM, the Executive Director was unable to provide evidence that the above employees had received all required in-service training initially and annually, as required.	S 190		
S 200	Organization And Management 2.4.12(l)(2) Administrative Management	S 200		

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S 200	Continued From page 4 2.4.12 (I) (2) Personnel Records 2. Said personnel records shall be reviewed and updated at intervals not to exceed twelve (12) months and shall include, but not be limited to, all of the following components: a. Completed job application and/or resume; b. Written statements of references or documentation of verbal reference check; c. Written functional job descriptions; (1) These descriptions shall be updated at intervals not to exceed twelve (12) months and shall include, but not be limited to, minimal qualifications for the position, major duties and responsibilities, and shall be signed and dated by the individual employee. d. Evidence of credentials, current professional licensure and/or certification; e. Documentation of education and/or continuing training, including continuing education units (CEUs) related to administrator certification, food management, etc., medication administration, and dementia care; f. Documentation of attendance at in-service training and/or orientation; g. Documentation of at least one (1) performance evaluation at intervals not to exceed twelve (12) months;	S 200		

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S 200	Continued From page 5 h. Signed copy of employee's awareness of resident's rights; i. Results of the criminal record (BCI) check. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to ensure personnel records contained all required documentation for four of six sample staff reviewed, Staff A,B,C, and F. Findings are as follows: 1) Record review of Staff A revealed a hire date of 03/15/2023. This employee was hired as a Registered Nurse/Director of Wellness. The record failed to reveal evidence of documentation of a signed written job description or a signed acknowledgement of resident rights. 2) Record review for Staff B revealed a hire date of 01/11/2023. This employee was hired as a Certified Nursing Assistant (CNA). The record failed to reveal evidence of documentation of references, a signed written job description, or a signed acknowledgement of resident rights. 3) Record review for Staff C revealed a hire date of 09/20/2022. This employee was hired as a CNA. The record failed to reveal evidence of documentation of references, a signed written job description, or a signed acknowledgement of resident rights. 4) Record review for Staff F revealed a hire date of 04/06/2022. This employee was hired as a CMT/CNA. The record failed to reveal evidence of documentation of references.	S 200	Audit of all employee records will be completed by 6/16/23 for all required documentation. New internal Personnel Records Review checklist to be utilized for all new hires to ensure compliance. Audit of 10% of existing employees and all new hires will be completed weekly x4 weeks and monthly x6 months. Audits will be reviewed quarterly in QA x6 months to ensure compliance.	

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S 200	Continued From page 6 During an interview on 04/28/2023 at approximately 3:20 PM, the Executive Director was unable to provide evidence the personnel records for Staff A,B,C, and F contained the required documentation.	S 200		
S 360	Residency Requirements 2.4.16(C) Resident Assessment/Service Plans 2.4.16 (C) Resident Assessments and Service Plans C. The Department-approved assessment form, or such other assessment form as approved by the Department, shall be utilized in completing the assessment on each resident who is admitted to the residence. (Approved Department form is available for downloading online at http://health.ri.gov/forms/assessment/AssistedLivingResident.pdf). 1. Assisted living residences not intending to use the Department's assessment form shall submit their proposed assessment forms with a cover letter of intent to the Center for Health Facilities Regulation as specified in § 2.4.6(A) of this Part. 2. All assessment forms shall report information appropriate to determine compatibility and compliance with the residency criteria, and shall indicate that the resident's needs can be met by the assisted living residence within its licensure level, and shall gather information appropriate for the development of an individualized service plan. a. The assessment form shall be designed to demonstrate compliance with the assisted living	S 360		

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S 360	Continued From page 7 residence's criteria for residency. b. The assessment form shall also be designed to demonstrate that the assisted living residence can meet the resident's needs and preferences. 3. The assessment form shall also be designed to provide information appropriate for the development of an individualized service plan in accordance with § 2.4.16(G)(1) of this Part. This Requirement is not met as evidenced by: Based on surveyor observation, record review, and staff interview it has been determined that the residence's assessment form failed to report the resident's needs and gather information appropriate for the development of an individualized service plan which also included all services provided by outside healthcare agencies, for four of eight sample residents reviewed, Resident ID #s 1,2,3, and 4. Findings are as follows: 1) ID #1 was admitted to the residence in March of 2022 with diagnoses including, but not limited to: congestive heart failure, dementia, and hypertension. Record review of ID #1's comprehensive assessment dated 01/16/2023 indicates he/she receives outside skilled nursing (SN) care for wound management. The assessment fails to reflect wound clinic visits for wound management services. Additionally, the assessment fails to reveal being updated to reflect discharge from SN and wound clinic services due to the resolution of the wound in March of 2023. 2) ID #2 was admitted to the residence on	S 360	The service plans and assessments for the identified residents will be updated to reflect all current and accurate information as directed by 6/9/23. WD or designee will audit all assessments and service plans for active residents receiving skilled services to be completed by 6/16/23. A weekly update from outside agencies to be provided to community for documentation purposes. WD or designee will update service plans as appropriate Community has requested change in Meridian form and policy for 90 day review to be instituted by 6/16/23. WD or designee will audit all assessments and service plans for active residents receiving skilled services. These audits will be completed weekly x4 weeks, then monthly x6 months. Audits will be reviewed quarterly in QA x6 months.	

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S 360	Continued From page 8 04/04/2023 from a skilled nursing facility (SNF) with diagnoses including, but not limited to: acute pulmonary edema, heart failure, and hypertension. The resident's Continuity of Care (COC) form from the SNF dated 04/04/2023 indicates he/she is being discharged with physician's orders and a referral for SN, physical therapy (PT), and occupational therapy (OT) services. The list provided by the Director of Wellness at entrance indicated the resident was receiving "PT/OT/SN" services. The resident's initial comprehensive assessment dated 04/03/2023 fails to reflect being updated to include these services with a start of care of 04/07/2023 and currently ongoing. 3) ID #3 was admitted to the residence in July of 2022 with diagnoses including, but not limited to: renal failure, hypertension, alcohol abuse, and nicotine dependence. Record review of ID #3's comprehensive assessments dated 07/11/2022, 08/05/2022, and 08/11/2022 do not indicate the resident is a smoker. A physician's order was obtained by the facility on 07/15/2022 to discontinue nicotine patches for smoking cessation due to the resident smoking. During an interview with the Director of Wellness upon entrance, it was stated that there are no residents with oxygen in the residence. Surveyor observation of the facility revealed there to be no residents with oxygen in the residence.	S 360		

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S 360	Continued From page 9 Record review of ID #3's comprehensive assessments dated 11/14/2022 and 04/28/2023 state in part, "...Currently uses oxygen (continuous/intermittent)...Yes, Resident safely removes oxygen prior to smoking..." Additionally, the 11/14/2022 and 04/28/2023 assessments indicate the resident has no history of substance abuse, an admitting diagnosis for this resident is alcohol abuse. 4) ID #4 was admitted to the residence in December of 2018 with diagnoses including, but not limited to: spinal stenosis, chronic fatigue, and dementia. The list provided by the Director of Wellness at entrance indicated the resident was receiving "SN" services. Record review of ID #4's comprehensive assessments dated 11/29/2022 failed to reveal being updated to reflect SN services related to a surgical wound with a start of care of 04/07/2023. The resident had visit notes written by the SN provider on 04/07/2023, 04/10/2023, 04/12/2023, 04/13/2023, 04/14/2023, 04/15/2023, 04/16/2023, 04/17/2023, and 04/21/2023. During an interview on 05/01/2023 at approximately 10:10 AM, the Executive Director and Director of Wellness were unable to provide evidence the comprehensive assessments for the above residents accurately reflected the resident's status and were updated when the resident had a change of condition, such as receiving outside services.	S 360		
S 380	Residency Requirements 2.4.16(G)(1) Resident Assessment/Service Plan	S 380		

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S 380	Continued From page 10 2.4.16 (G) (1) Service Plans 1. Within a reasonable time after move-in, not to exceed seven (7) days, the Administrator shall be responsible for the development of a written service plan based on the initial assessment. The service plan shall include at least: a. The services and interventions needed, including all services provided by outside healthcare agencies (e.g., home nursing care, hospice); b. Description, frequency, duration relating to the service or intervention, including personal assistance, medication, special diets, recreational activities, and other similar services rendered; c. Party responsible for arranging and/or providing the service; and d. The resident's requested and/or therapeutically needed recreational and social activities. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined that the residence failed to document a description of the services and interventions needed on the service plan, including all services provided by outside healthcare agencies, and to ensure the service plan was reviewed at intervals not to exceed twelve (12) months, for six of eight sample residents reviewed, Resident ID #s 1,2,3,4,5, and 6. Findings are as follows: 1) ID #1 was admitted to the residence in March of 2022 with diagnoses including, but not limited	S 380	The service plans for resident IDs 1-6 will be updated to reflect all outside services received by 6/9/23. Weekly updates to be received from outside agencies providing services for documentation purposes. WD or designee to complete audit of all service plans for active residents receiving outside services and updates to be completed by 6/16/23. WD or designee to complete auditof all service plans for active residents receiving outside services will be completed weekly x4 weeks, then monthly x6 months. Audits will be reviewed quarterly in QA x6 months. In-service to be conducted with WD regarding accurate 90 day nurse review and updating service plans.	

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S 380	Continued From page 11 to: congestive heart failure, dementia, and hypertension. Record review of ID #1's service plan dated 03/16/2023 failed to reflect he/she received outside skilled nursing (SN) care for wound management and wound clinic visits for wound management services. Additionally, the service plan failed to reveal being updated to reflect discharge from SN on 03/24/2023 and wound clinic services due to the resolution of the wound in March of 2023. 2) ID #2 was admitted to the residence on 04/04/2023 from a skilled nursing facility (SNF) with diagnoses including, but not limited to: acute pulmonary edema, heart failure, and hypertension. The resident's Continuity of Care (COC) form from the SNF dated 04/04/2023 indicates he/she is being discharged with physician's orders and a referral for SN, physical therapy (PT), and occupational therapy (OT) services. The list provided by the Director of Wellness at entrance indicated the resident was receiving "PT/OT/SN" services. The resident's initial service plan dated 04/03/2023 fails to reflect being updated to include these services with a start of care of 04/07/2023 and currently ongoing. 3) ID #3 was admitted to the residence in July of 2022 with diagnoses including, but not limited to: renal failure, hypertension, alcohol abuse, and nicotine dependence. Record review of ID #3's service plan dated	S 380		

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S 380	Continued From page 12 07/14/2022 and updated 08/05/2022 does not indicate the resident is a smoker. A physician's order was obtained by the facility on 07/15/2022 to discontinue nicotine patches for smoking cessation due to the resident smoking. 4) ID #4 was admitted to the residence in December of 2018 with diagnoses including, but not limited to: spinal stenosis, chronic fatigue, and dementia. The list provided by the Director of Wellness at entrance indicated the resident was receiving "SN" services. Record review of ID #4's service plan dated 10/30/2022 failed to reveal being updated to reflect SN services related to a surgical wound with a start of care of 04/07/2023. The resident had visit notes written by the SN provider on 04/07/2023, 04/10/2023, 04/12/2023, 04/13/2023, 04/14/2023, 04/15/2023, 04/16/2023, 04/17/2023, and 04/21/2023. 5) ID #5 was admitted to residence in March of 2021. Record review revealed the resident's last service plan to be dated 03/16/2022. 6) ID #6 was admitted to the residence in August of 2020 with diagnoses including, but not limited to: seizure disorder, dementia, and type II diabetes. The list provided by the Director of Wellness at entrance indicated the resident was receiving "Hospice" services and to have a variance from the state agency for these services.	S 380		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 380	Continued From page 13 Record review revealed ID #6's service plan dated 01/09/2023 failed to be updated to reflect admission to hospice services with a start of care date of 04/04/2023. During an interview on 05/01/2023 at approximately 10:15 AM, the Executive Director and Director of Wellness were unable to provide evidence the service plans for the above residents accurately reflected the resident's status, were updated when the resident had a change of condition, such as receiving outside services, and ensure service plans were reviewed at an interval not to exceed twelve months.	S 380		
S 560	Residential Care Services 2.4.24(A)(3)(b) Medication Services 2.4.24 (A) (3) (b) Medication Services b. For assisted living residences licensed at the M1 level, licensed employees (registered medication aides, registered nurses, licensed practical nurses) may administer oral or topical drugs and monitor health indicators. However, schedule II medications shall only be administered by licensed personnel. The physician or nurse supervisor shall conduct and document quarterly evaluations of the registered medication aides who are administering drugs and place a copy in the employee's personnel record. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined the residence failed to have the physician or nurse supervisor conduct and document quarterly evaluations of the registered medication aides who are administering drugs	S 560	New CMT observation forms were completed for all CMTs 5/19/23. WD or designee to complete med observation forms quarterly and with new hires. Calendar created to reflect due dates. WD or designee to complete audit of all CMTs monthly x12 months. Audits will be reviewed quarterly in QA x12 months to ensure compliance.	

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S 560	Continued From page 14 and place a copy in the employee's personnel record for four of four medication aides reviewed, Staff E,F,G, and H. Findings are as follows: 1) Record review for Staff E revealed a hire date of 02/25/2022. This employee was hired as Certified Medication Technician (CMT)/CNA. Record review revealed one evaluation for this staff member dated 03/28/2022. 2) Record review for Staff F revealed a hire date of 04/06/2022. This employee was hired as a CMT/CNA. Record review revealed evaluations for this staff member dated 04/20/2022, 08/30/2022, 01/03/2023, and 04/03/2023. 3) Record review for Staff G revealed a hire date of 07/31/2012. This employee was hired as a CMT/CNA. Record review revealed evaluations for this staff member dated 04/03/2020, 10/22/2020, 03/04/2021, 10/21/2021, 05/31/2022, 08/30/2022, 01/05/2023, and 04/26/2023. 4) Record review for Staff H revealed a hire date of 04/07/2010. This employee was hired as a CMT/CNA. Record review revealed evaluations for this staff member dated 04/02/2020, 10/29/2020, 04/13/2021, 08/03/2021, 02/09/2022, 09/07/2022, 12/29/2022, and 04/17/2023. During an interview on 04/28/2023 at	S 560		

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S 560	Continued From page 15 approximately 2:30 PM, the Director of Wellness was unable to provide evidence quarterly medication aide evaluations were conducted, documented, and filed in the personnel record for Staff E,F,G, and H, as required.	S 560		
S 565	Residential Care Services 2.4.24(B)(1) Medication Services 2.4.24 (B) (1) Administration of Medications 1. Residences licensed at the M1 level may administer medications to residents including, but not limited to, removing medication containers from storage, assisting with the removal of a medication from a container for residents with disability which prevents independence in this act, and/or administering the medication directly to the resident. a. The resident or guardian must provide written authorization for the residence to provide administration of medications. b. Medications shall be administered in accordance with written orders of a physician. The residence must provide in writing, a description of services provided by the residence to each physician, including limitations on service. c. All medications must be checked against a physician's orders by a licensed nurse, or pharmacist. d. The resident must be identified prior to administration of any medication. e. The medication must be in the original pharmacy-dispensed container with proper label	S 565		

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S 565	Continued From page 16 and directions attached and be administered in accordance with such label. f. Injectable medications, including but not *limited to insulin, which cannot* be self-administered by the resident, must be administered by a licensed nurse. g. There shall be written a policy/procedure for the disposal of hypodermic needles, syringes and other such instruments that is in compliance with rules and regulations governing Hypodermic Needles, Syringes & Other Such Instruments (Part 20-15-6 of this Title). (1) The legal destruction of hypodermic needles, syringes or other such instruments is the responsibility of the last entitled or authorized possessor. (AA) All personnel or residents legally authorized to use disposal syringes and needles, shall destroy them after one (1) use. (BB) Excess and undesired needles, syringes and other such instruments shall be stored in impervious, rigid, puncture- resistant container for disposal. Intact needles shall be placed directly into the collection containers. (CC) Personnel handling disposal waste materials such as needles, syringes, and other such instruments may treat and destroy such waste by a DEM-approved alternative treatment/destruction technology or prepare the regulated medical waste for off-site transport by a DEM-permitted medical waste transporter. *h. Individual medication records must be*	S 565		

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S 565	Continued From page 17 retained for each resident to whom medications are being administered and each dose administered to the resident must be properly recorded. i. Any medication administered by the residence and refused by a resident shall be documented and reported, as appropriate. j. Medications shall be stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access. Provisions for safe storage may include lockable containers, secure spaces, or lockable units, as appropriate to the residence and the resident population. k. All medication in the residence, regardless of whether controlled by employees or by the resident, shall be stored securely as stated in § 2.4.24(A)(3)(a)(8) of this Part. l. All centrally stored medications shall be maintained in accordance with manufacturer's labeling and administered by authorized personnel. This Requirement is not met as evidenced by: Based on surveyor observation, record review and staff interview, it has been determined that the residence failed to ensure that medications shall be stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access for three of three sample residents reviewed for medication administration and two medication carts, ID #'s 1,2, and 6. Findings are as follows:	S 565		

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S 565	Continued From page 18 According to Mosby's 4th Edition, "Fundamentals of Nursing" page 314, states in part, "...The physician is responsible for directing medical treatment. Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm the clients..." 1) During surveyor observation on 04/27/2023 at approximately 12:40 PM, in the presence of Staff I, Certified Medication Technician (CMT)/Certified Nursing Assistant (CNA), the following medication discrepancies were identified on the third-floor medication cart relative to ID #2: -Atorvastatin 10 mg (milligrams) available on the cart to be dispensed, physician's order discontinued on 04/15/2023 -Polyvinyl Alcohol 1.4% Drops, the medication was currently prescribed but unavailable -Lisinopril 5 mg, was identified to have directions on the medication administration record (MAR) which differed from those on the medication card. The medication card indicated parameters for usage, the MAR did not. 2) During a subsequent observation of the cart with Staff I, it was identified that a cough medication for ID #7 was available for use without an active physician's order. A family member was requesting usage of the medication, but the medication had been discontinued on 02/05/2023. 3) During surveyor observation of the first-floor special care unit medication cart at approximately 1:00 PM, in the presence of Staff G, CMT/CNA, the following medication discrepancies were identified relative to ID #1: -Milk of Magnesia 400 mg/5 ml (milliliter), the	S 565	ID#1: - Milk of Magnesia and tylenol were ordered and added to the cart. ID#2: - atorvastatin removed from the cart. - polyvinyl 1.4 drops were ordered and added to the cart. - lisinopril clarified and MAR updated to reflect appropriate order. ID #6 has been discharged. ID #7 cough medication order was clarified with MD and updated in cart and MAR. WD or designee will complete review of physician orders and med cart audit to ensure medications are available with each scheduled assessment. In-service to be completed with CMTs/LPNs regarding medication ordering/removal by 6/9/23. An audit of all med carts to be completed by 6/16/23 to ensure MAR matches available medications. Audit of med cart and MAR for 10% of residents to be completed weekly x4 weeks, then monthly x6 months. Audits to be reviewed quarterly in QA x6 months.	

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S 565	Continued From page 19 medication was currently prescribed but unavailable -Acetaminophen 325 mg, the medication was currently prescribed but unavailable -Senna, available on the cart to be dispensed without a physician's order -Purelax, available on the cart to be dispensed without a physician's order 4) During a subsequent observation in the presence of Staff G, the following was identified relative to ID #6: - Vitamin D3 125mg, available on the cart to be dispensed, physician's order discontinued on 04/04/2023 -Milk of Magnesia 400 mg/5 ml, the medication was currently prescribed but unavailable -Senna 8.6 mg, the medication was currently prescribed but unavailable -Miralax 17 gm (gram), the medication was currently prescribed but unavailable -Tylenol 325 mg, the medication was currently prescribed but unavailable During an interview on 04/27/2023 at approximately 1:20 PM, the Director of Wellness acknowledged all currently prescribed medication should be available for administration, physician's orders and medication cards should match, and discontinued medications should be removed from the medication carts.	S 565		
S 705	Physical Plant 2.4.30(I) Safety Requirements 2.4.30 (I) Safety Requirements I. Each residence shall develop and maintain a written plan and procedure for the evacuation of	S 705		

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S 705	Continued From page 20 the premises in case of fire or other emergency, based on F1 / F2 licensure requirements, Fire Safety Code-General Provisions (R.I. Gen. Laws Chapter 23-28.1) requirements. 1. Emergency steps of action shall be clearly outlined and posted in conspicuous locations throughout the residence. 2. Drills simulating fire emergencies, testing the effectiveness of the fire evacuation plan shall be conducted at least six (6) times per year on a bimonthly basis with a minimum of two (2) drills conducted during the night when residents are sleeping with documentation of observed ability of residents to carry out evacuation procedures. At least fifty percent (50%) of these drills shall be obstructed drills, as defined in Fire Safety Code-General Provisions (R.I. Gen. Laws Chapter 23-28.1). 3. The drills shall be permitted to be announced in advance to the residents. The drills shall involve the actual evacuation of all residents to an assembly point as specified in the emergency plan and shall provide residents with experience in egressing through all exits and means of escape required by the Fire Safety Code-General Provisions (R.I. Gen. Laws Chapter 23-28.1). Exits and means of escape not used in any fire drill shall not be credited in meeting the requirements of the Fire Safety Code-General Provisions (R.I. Gen. Laws Chapter 23-28.1). a. Documentation of fire drills shall be maintained and shall include no less than the following information: (1) Name of the person conducting the drill; (2) Date and time of the drill; (3) Amount of time taken to evacuate the	S 705		

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S 705	Continued From page 21 building or unit; (4) Type of drill (i.e., obstructed or unobstructed); (5) Record of problems encountered and steps taken to rectify them; (6) Employee observation of each resident's ability to carry out evacuation procedures. 4. Residents shall be instructed in all alternative methods of escape since the primary exit may be unusable due to fire and/or smoke. Such instruction shall be documented in the record described in § 2.4.30(l)(3)(a) of this Part. 5. Each new resident shall be oriented to the fire drill procedure on admission, with documentation of the orientation placed in the resident's record. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to ensure that drills simulating fire emergencies conducted at least six (6) times per year on a bimonthly basis documented at least fifty percent of the fire drills conducted in the residence were obstructed drills, as defined in Fire Safety Code-General Provisions (R.I. Gen. Laws Chapter 23-28.1). Findings are as follows: Record review of the fire drills conducted from March 2022 through March 2023 revealed 14 drills and one incident that caused the alarm to sound. Review of the fire drill documentation revealed 2 obstructed drills, 10 unobstructed drills, and 2 drills failed to reveal the type of drill. Review of the fire drill schedule revealed the 2 drills (10/27/2022 and 11/26/2022) which failed to document the type of drill to be also undocumented on the schedule.	S 705	Maintenance Director re-educated on fire drill policy and regulation 5/26/23. Calendar created to reflect both shift and level of obstruction to maintain compliance. ED or designee to audit drills monthly x3 months, then quarterly x9 months. Audits will be reviewed quarterly in QA x12 months.	

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S 705	Continued From page 22 During an interview on 10/27/2022 at approximately 11:45 AM, the Executive Director was unable to provide evidence at least fifty percent of the fire drills conducted were obstructed drills, as required.	S 705		
S 915	Limited Health Services License Require 2.6.2(M) Specific Requirements 2.6.2 (M) Specific Requirements M. Assisted living residences licensed to provide limited health services are required to have a licensed physician, a certified nurse practitioner or a licensed physician assistant as a member of the Quality Improvement Committee as defined in § 2.4.3 of this Part. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined the residence, which is licensed to provide limited health services, failed to have a licensed physician, a certified nurse practitioner, or a licensed physician assistant as a member of the Quality Improvement Committee. Findings are as follows: Record review of the attendance for meetings held in 2021 and 2022 failed to reveal a licensed physician, a certified nurse practitioner, or a licensed physician assistant in attendance. During an interview on 05/01/2023 at approximately 10:00 AM, the Executive Director acknowledged a licensed physician, a certified nurse practitioner, or a licensed physician	S 915	Staff A-F will be educated on the following as required by 6/9/23: 1. Pressure ulcer treatment and prevention; 2. Simple wound care including postoperative suture care/removal and stasis ulcer care; 3. Ostomy care including appliance changes for residents with established stomas; 4. Urinary catheter care; 5. Reporting changes in condition; 6. Signs and symptoms of infection(s); and 7. Signs and symptoms of dehydration. WD or designee will audit records for all active licensed care staff by 6/16/23 to ensure compliance. All new hires will receive required education as indicated above from the Wellness Director prior to working alone. Audit of new hires to be completed weekly x4 weeks, then monthly x6 months.	

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S 915	Continued From page 23 assistant were not in attendance as a member of the Quality Improvement Committee.	S 915	Audits to be reviewed quarterly in QA x6 months.	
S 940	Limited Health Services License Require 2.6.2(R) Specific Requirements 2.6.2 (R) Staff Training- Limited Health Services All employees, including those who will assist residents with personal care receive at least four (4) hours of orientation and training in the areas listed below prior to beginning work alone with a resident receiving limited health services. Staff will be provided no less than two (2) hours of continued education in the following areas at intervals not to exceed twelve (12) months. 1. Pressure ulcer treatment and prevention; 2. Simple wound care including postoperative suture care/removal and stasis ulcer care; 3. Ostomy care including appliance changes for residents with established stomas; 4. Urinary catheter care; 5. Reporting changes in condition; 6. Signs and symptoms of infection(s); and 7. Signs and symptoms of dehydration. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined the residence failed to ensure that new staff received in-servicing training within ten (10) days of hire and prior to beginning work alone and existing staff received on-going, at intervals not to exceed twelve (12) months, in-servicing training for four of six sample employees, Staff ID's A,B,C,D,E and F. Findings are as follows:	S 940		

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S 940	Continued From page 24 1) Record review of Staff A revealed a hire date of 03/15/2023. This employee was hired as a Registered Nurse/Director of Wellness. 2) Record review for Staff B revealed a hire date of 01/11/2023. This employee was hired as a Certified Nursing Assistant (CNA). 3) Record review for Staff C revealed a hire date of 09/20/2022. This employee was hired as a CNA. 4) Record review for Staff D revealed a hire date of 01/04/2021. This employee was hired as a CNA. 5) Record review for Staff E revealed a hire date of 02/25/2022. This employee was hired as Certified Medication Technician (CMT)/CNA. 6) Record review for Staff F revealed a hire date of 04/06/2022. This employee was hired as a CMT/CNA. Record review failed to reveal evidence that the above employees had received all required in-service training in the following areas: 1. Pressure ulcer treatment and prevention; 2. Simple wound care including postoperative suture care/removal and stasis ulcer care; 3. Ostomy care including appliance changes for residents with established stomas; 4. Urinary catheter care; 5. Reporting changes in condition; 6. Signs and symptoms of infection(s); and 7. Signs and symptoms of dehydration. During an interview on 04/28/2023 at approximately 2:45 PM, the Executive Director	S 940		

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S 940	Continued From page 25 and Director of Wellness were unable to provide evidence that the above employees had received all required in-service trainings relative to limited health services.	S 940		