RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01347	A. BUILDING _____ B. WING _____	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE AT WATERMAN LAKE-LP	715 PUTNAM PIKE SMITHFIELD, RI 02828

(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 003	Initial Comments An unannounced biennial State Licensure survey was conducted at this residence. Deficiencies were identified relative to the State Licensure survey.	S 003	The Filing of this plan of Correction (POC) does not constitute that the deficiencies alleged did in fact exist; rather this POC is filed as evidence of the community's continuing commitment to high quality resident care in full compliance with State regulations.	
S 285	Residency Requirements 2.4.14.A Residency Requirements 2.4.14 (A) Residency Requirements A. Each licensee, or his/her designee, through the assessment and evaluation procedures delineated in these regulations (see § 2.4.16(C) of this Part) shall be responsible to ensure that admission to and residency in an assisted living residence be limited to those individuals who meet the definition of "resident" in accordance with § 2.3(A)(32) of this Part. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence retained a resident that does not meet the definition of a resident for 1 of 5 residents reviewed, ID #1. Findings are as follows: Per the regulations as defined in section 2.6.2 states in part. "...B. Assisted living residences licensed to provide limited health services may provide any or all of the following services: 1. Stage I and stage II pressure ulcer treatment and prevention..." The following are defined in part by The National Pressure Ulcer Advisory Panel: "...Stage 2 Pressure-partial-thickness loss of skin...the wound bed is viable, pink or red, moist ...fat is not visible and deeper tissue is not	S 285	S 285 Resident ID # 1 has experienced no untoward effects as a result of the surveyor findings. On August 23, 2023, Resident #1 was given a 30-day notice requiring [redacted] to move to a higher level of care, a copy of which was provided to the DOH. Resident #1 has since moved to The Atrium, the skilled	09/1/23

RECEIVED
SEP 06 2023
FACILITIES REGULATION

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Oliver Harvey COO — (X6) DATE 9/6/2023

STATE FORM 6899 — If continuation sheet 1 of 9

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S 285	Continued From page 1 visible...slough [dead cells that accumulate in wound] and eschar [dead tissue that interferes with wound healing] are not present...Stage 3 Pressure-Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue. Slough -yellow, tan, gray, green or brown drainage and/or eschar in the wound bed...Stage 4 Pressure ulcer: Full thickness and tissue loss with exposed or directly palpable...tendon..." Record review revealed the resident initially moved into the residence in April of 2023 and was readmitted in July of 2023. S/he has diagnoses including, a Stage 3 pressure ulcer and muscle weakness. Record review revealed a comprehensive assessment dated 4/6/2023 and updated on 7/14/2023 which states in part, "...right heel ulcer Stage 3..." Record review revealed the following progress notes from the outside agency: - 8/8/2023: "right heel pressure ulcer 3...50% slough [a collection of dry dead tissue in a wound]..." - 8/1/2023: "right heel pressure ulcer [stage] 3...50% slough..." - 7/28/2023: "right heel pressure ulcer [stage] 3...20% slough..." - 7/11/2023: "right heel pressure ulcer [stage] 3...50% slough..." - 4/27/2023: "Right heel wound care	S 285	nursing unit at The Village at Waterman Lake. At present time, no other residents have stage three pressure ulcers, as evidenced by the ongoing communication between Visiting Nurses and the Director of Nursing. Going forward, we will utilize our assessment tool for any new admission to The Village at Waterman Lake, which prevents us from accepting a resident who has a stage 3 or greater pressure ulcer; a copy of this assessment tool is attached. Were an existing resident's stage 1 or stage 2 wound to advance to a stage 3, immediately upon it being reported to us by the visiting nurse services, we would facilitate a transfer of the resident to skilled care.	

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S 285	Continued From page 2 provided-noted with slough tissue..." - 4/26/2023: "...Wound care to right heel pressure ulcer...apply skin prep to peri [surrounding] wound and to eschar..." During a surveyor interview on 8/11/2023 at approximately 9:00 AM with the Director of Nursing of the Lodge, she acknowledged that the residence does not have a limited health services license. Additionally, she acknowledged the resident was readmitted into the residence in July of 2023 with a stage 3 pressure ulcer.	S 285		
S 490	Residential Care Services 2.4.21.C Dietetic Services 2.4.21 (C) Dietetic Services C. The food service in each residence shall comply with the appropriate requirements of R.I. Gen. Laws Chapters 21-27 and 21-31, Rhode Island Food Code (Part 50-10-1 of this Title), and such other applicable statutory or regulatory provisions. 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 comply with the appropriate requirements of the Rhode Island Food Code for the Courtyard and the Lodge kitchens. Findings are as follows: An initial tour of the Lodge kitchen on 8/10/2023	S 490		

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S 490	Continued From page 3 at approximately 8:30 AM revealed the following in the walk-in freezer: - freezer burn on a five-pound bag of kielbasa sausage - underneath the shelves along the parameter of the freezer contained papers, tape, cup lids, and ice cream frozen to the floor etc. During a surveyor interview with the Food Service Director (FSD) immediately following the above observations, he acknowledged the bag of kielbasa had freezer burn and that the floor in the walk-in freezer needed to be cleaned. Record review of section 4-601.11 of the Rhode Island Food Code edition 2018 states in part,"... (c) Nonfood-Contact Surfaces of Equipment shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris..." Record review of section 2-402.11 of the Rhode Island Food Code edition 2018 states in part, "(A)...FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS..." An initial tour of the Courtyard kitchen on 8/10/2023 at 10:44 AM revealed the following: . . . - heavy accumulation of dust inside the soda machine on the exhaust fan. - six, twenty-four-ounce bags of Sysco Classic Gelatin powder without an expiration date.	S 490	**08/11/23** • The kielbasa referenced was thrown out immediately. An inspection of the remaining freezers found no evidence of any other freezer burnt food items. No resident was affected by the freezer burnt kielbasa because it had not been served. The manager will monitor items in freezer going forward to ensure all food items are properly covered and free from freezer burn. • The walk-in freezer referenced has been scraped and cleaned of any and all debris and ice cream as of the day the day of inspection. No residents were affected by the freezer's condition. Manager will continue to monitor walk-in freezers to ensure cleanliness by conducting inspections on a minimum basis of once weekly. 9/8/23 • A service call was placed to the company responsible for maintenance of the soda machine and a representative is schedule to come out by September 8, 2023, to clean the exhaust fan. We have requested the company add this cleaning to their routine maintenance schedule, which is every 3-6 months or sooner if needed, to prevent dust from accumulating in future. No other machines were affected nor were residents negatively impacted due to the dusty fan. 8/11/23 • The foodstuffs lacking expiration dates were disposed of immediately. The Food Distributor, SYSCO, has been made aware of the missing expiration dates and are using the order numbers we provided to improve quality	

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S 490	Continued From page 4 - nine, twenty-four-ounce boxes of Sysco Classic vanilla pudding and pie filling mix without an expiration date. A surveyor observation at 11:20 AM revealed a Chef, Staff A, preparing the lunch meal without wearing a beard restraint. Additionally, the Service Staff Manager, Staff B, was observed in the food preparation area where meals were being prepared without wearing a beard restraint. During a surveyor interview with the FSD following the above observations, he was unable to provide evidence that the above mentioned foods had expiration dates. He further acknowledged that there were no beard restraints for kitchen staff to use in the residence.	S 490	control on their end. The remaining items in the food storage area were examined and none were found to be lacking expiration dates. Effective immediately, we will make sure to confirm expiration dates on boxes of food we receive from vendors and in the event any are missing expiration dates, we will refuse to accept them. All team responsible for accepting orders have been trained on this policy. 9/11/23 • All food employees with facial hair began wearing masks the day of inspection, beard restraints were ordered immediately following the inspection, and provided to all kitchen staff effective August 15, 2023. Going forward, all kitchen staff are required to cover facial hair with beard restraints while working, and all relevant team have now been trained on this policy.	
S 555	Residential Care Services 2.4.24.A.3.a Medication Services 2.4.24 (A) (3) (a) Medication Services 3. Each residence shall provide medication services only in accordance with the appropriate level of licensure for which the residence is licensed, which shall be as follows: a. For assisted living residences licensed at the M2 Level, assistance with self- administration by unlicensed employees means that the residence shall only be responsible for reminding residents to take medications, and: (1) The resident or guardian must provide written authorization for the residence to provide assistance with the self-administration of medications; (2) The residence must provide, in	S 555		

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S 555	Continued From page 5	S 555		

writing, a description of services provided by the residence to each physician prescribing for a resident, including limitations on services;

(3) Employees may only remind the resident and observe the self- administration of medication;

(4) The resident shall not require nursing assessment of health status before receiving the medication, nor nursing assessment of the therapeutic or side effects after the medication is taken;

(5) Except as provided in § 2.4.24(A)(3)(a)(7) of this Part, the medication shall be in the original pharmacy-dispensed container with proper label and directions attached;

(6) Unlicensed employees shall not monitor health indicators, make medication decisions, adjust medications or provide other medical or nursing decisions;

(7) For residents capable of self-administration of medication but who wish to ask assisted living residence employees to use a medi-set (pre-poured packaging distribution system), only registered medication aide, licensed nurse, or pharmacist shall organize the medications for up to one (1) week;

(8) All medication in the residence, regardless of whether controlled by employees or by the resident, shall be stored securely. All medications shall be stored in a manner to prevent spoilage, dosage errors, administration errors or inappropriate access by other residents, visitors, or unauthorized employees. Provisions

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S 555	Continued From page 6 for safe storage may include lockable containers, secure spaces, or lockable units, as appropriate to the residence and the resident population. (9) There shall be documented policies or procedures regarding medication disposal and inventory procedures in the policies and procedures manual. (10) Each person assisting residents with self-administration of medications shall: (AA) Be an employee of the residence; (BB) Be literate in English; and (CC) Receive orientation, instruction and on-the-job training regarding relevant policies and procedures; or (DD) Be a licensed nurse. (EE) M2 level facilities may limit record keeping for residents who retain possession and control of medications to the requirements of § 2.4.15(A)(6) 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 failed to ensure that medications shall be stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, or inappropriate access for 2 of 6 medication carts observed. Findings are as follows:	S 555		

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S 555	Continued From page 7 1. During a surveyor observation of the McIntosh wing medication cart on 8/10/2023 at approximately 10:10 AM in the presence of a Certified Medication Technician (CMT), Staff C, revealed a Breo Ellipta 200/25 mcg (microgram) inhaler opened and not dated. Manufacturer instructions indicate to discard inhaler 6 weeks after opening. During a surveyor interview immediately following this observation, Staff C acknowledged the inhaler was opened and not dated. 2. A surveyor observation of the Baldwin wing medication cart on 8/10/2023 at approximately 10:20 AM in the presence of a CMT, Staff D, revealed the following: - One Fluticasone Propionate and Salmeterol 250-50 mcg inhaler with an open date of 7/3/2023 and a discard date of 8/3/2023. Manufacturer instructions indicate to discard the inhaler one month after opening. - One Wixela 250/50 mcg inhaler with an open date of "March 28". Manufacturer instructions indicate to discard the inhaler one month after opening. - One Incruse Ellipta 62.5 mcg inhaler with an open date of "June 22". Manufacturer instructions indicate to discard the inhaler 6 weeks after opening. During a surveyor interview immediately following this observation, Staff D acknowledged the inhalers were opened and not dated. During a surveyor interview with the Director of Nursing of the Courtyard, on 8/10/2023 at	S 555	9/6/23 There were no untoward effects experienced by residents as a result of the surveyor findings. The four inhalers in question, all of which were provided by the family member of a new resident, were discarded immediately. Med cart inspections performed effective September 6, 2023, found no other expired inhalers or other medications. Going forward, the Director of Nursing will perform Med carts audits of the carts in all three units on a minimum quarterly basis, to ensure all inhalers are dated upon opening and/or disposed of within the required timeframe per the manufacturer instruction. CMT's on all three units have been in-serviced on the need to date opened inhalers and dispose of them within the required timeframes per the manufacturer instructions.	

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S 555	Continued From page 8 approximately 1:50 PM, she could not provide evidence the inhalers were dated when they were opened and the expired inhalers were discarded.	S 555		