RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01519	A. BUILDING: _____ B. WING _____	C 05/07/2025

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

(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 complaint/incident investigation survey and a State Licensure survey (ZN5B11, 05/07/2025) were conducted at this residence. A deficiency was identified as a result of this survey.	S 003		
S 230	Organization And Management 2.4.13.A Management Of Services 2.4.13 (A/B) Management of Services A. Each residence shall provide services with adequate professional and ancillary employees and in accordance with applicable state law. Further, the residence shall assure that all services are rendered in a safe and effective manner and consistent with the requirements herein. The residence shall provide all care and services to all residents in accordance with the prevailing community standard of care. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to provide care and services in accordance with the prevailing community standard of care relative to administering medications in accordance with written physician's orders for the singular resident reviewed, Resident ID #1. Findings are as follows:	S 230	1. Resident ID #1 has been discharged from the community. 2. Audit to be completed on all new admissions admitted in the last thirty days to ensure orders were transcribed correctly. To be completed by 6/6/25. 3. Education will be completed by 6/6 on the admission procedure and checklist to ensure orders are captured on admission. 4. 100% of new admissions will be audited weekly x4 weeks, monthly x5 months, and reviewed in Quarterly QA x6 months for continued compliance. Received MAY 30 2025 Facilities Regulation	

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ALRA | (X6) DATE: 5/30/25

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S 230	Continued From page 1 Review of a report sent to the Rhode Island Department of Health on 5/1/2025 alleges there were medication errors relative to Resident ID #1's readmission on 4/25/2025. 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 physician's orders unless they believe the orders are in error or would harm the clients..." Record review of Resident ID #1 revealed he/she was admitted to the residence in August of 2024 with diagnoses including, but not limited to: dementia, heart failure, and myocardial infarction (a blockage of blood flow to the heart causing a heart attack). Review of a document titled, "Transition of Care Communication" relative to admission at a higher level of care 4/15/2025 through 4/25/2025 revealed the following discharged medication orders: -"Acetaminophen 325 mg (milligrams) oral tablet, 650 mg=2 tab, Oral, q6hr (every 6 hours), PRN (as needed)..." -"Calmoseptine 0.44%-20.6% topical ointment, 1 app. Topical, BID (twice daily)..." -"melatonin 5 mg oral tablet, 5 mg=1 tab, Oral, QHS (at hours of sleep), PRN..." -"metoprolol succinate 50 mg oral tablet, extended release, 50 mg=1 tab, Oral, Daily" -"miconazole 2% topical powder, 1 app, Topical,	S 230		

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S 230	Continued From page 2 **BID..."** -"Miralax, 17 gm= 1 EA {each), Oral, Daily, PRN" -"sertraline 50 mg oral tablet, 25 mg=0.5 tab, Oral, Daily" -"traZODone 50 mg oral tablet, 50 mg=1 tab, Oral, OHS" -"traZODone 50 mg oral tablet, 50 mg=1 tab, Oral, QHS" -"Tums 500 mg oral tablet, chewable, 500 mg= 1 tab, Oral, TID {three times daily), PRN" Record review of the medication administration record {MAR) failed to reveal evidence the above-mentioned medications were transcribed onto the resident's MAR upon his/her return to the residence. Review of a statement from a telephone interview on 4/30/2025 at 12:42 PM, between Staff C and the Administrator, revealed that the resident returned from a higher level of care on 4/25/2025 in the early afternoon. Staff C indicated that she faxed the discharge orders to the pharmacy; however, she further indicated that she didn't realize the fax to the pharmacy did not go through. Additionally, when Staff C was reviewing the orders on 4/25/2025 she identified two orders for metoprolol: one for metoprolol tartrate and one for metoprolol succinate, which she alleged she clarified with the on-call physician's line on Saturday the 26th. Furthermore, Staff C indicated she gave the resident metoprolol succinate on 4/26, 4/27, and 4/28/2025. Record review of the facility's investigation	S 230		

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S 230	Continued From page 3 revealed Staff C failed to fax the orders to the pharmacy until 4/27/2025 at 10:08 AM. Further review of the facility's investigation failed to reveal evidence of the telephone order that Staff C alleges she received from the on-call physician's office to discontinue the metoprolol tartrate. Staff C indicated that the order was still not on the MAR on 4/27 and tried to manually enter the order but was unsuccessful. She further indicated that she had been passing the metoprolol from memory. The April MAR lacked evidence the appropriate medication for hypertension was administered on 4/26, 4/27, and 4/28/2025. The record failed to reveal metoprolol after 4/28/2025. During a surveyor interview with the Administrator on 5/5/2025 at approximately 9:00 AM, she revealed Staff C was not scheduled on 4/29/2025. During a surveyor interview with the Administrator on 5/6/2025 at approximately 11:00 AM, she indicated Staff C failed to reconcile the resident's medications when he/she returned on 4/25/2025 and gave the metoprolol without clarifying the order with the physician. Additionally, she revealed the resident did not get his/her metoprolol on the 29th since Staff C did not inform anyone that the resident was prescribed this medication and it was not showing on the electronic MAR. Furthermore, she revealed the resident had a fall and was sent to the hospital on the 29th and was admitted with a left knee fracture.	S 230		

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S 003	Initial Comments An unannounced biennial State licensure survey and a complaint/incident survey (3PDP11, ACTS #s 100550, 100596, and 100623) were conducted at this residence. Deficiencies were identified relative to both surveys.	S 003		
S 200	Organization And Management 2.4.12.I.2 Administrative Management 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;	S 200	1. Staff A and C have since been terminated. 2. Staff B to be educated and sign a copy of resident rights by 6/6/25. 3. A house wide audit of current associate files to be completed by 6/13/25 to ensure compliance with signed copy of resident rights. 4. Education to be completed with ED on employee personnel file requirements by 6/6/25. BOM position vacant at this time. Upon hire, BOM to be educated on requirements. 5. 100% of new hire personnel files with be audited weekly x4 weeks, monthly x5 months, and reviewed in quarterly QA x6 months for continued compliance.	

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S 200	Continued From page 1 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; 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 3 of 7 sample staff reviewed, Staff A, B, and C. Findings are as follows: The following personnel records failed to reveal evidence of a signed acknowledgement of resident rights: 1) Record review of Staff A revealed a hire dale of 9/12/2024. This employee was hired as a Registered Nurse/Director of Wellness. 2) Record review for Staff B revealed a hire date of 12/20/2023. This employee was hired as a Certified Nursing Assistant (CNA). 3) Record review for Staff C revealed a hire date of 6/24/2024. This employee was hired as a Licensed Practical Nurse.	S 200		

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S 200	Continued From page 2 During a surveyor interview on 5/5/2025 at approximately 2:00 PM with the Administrator, she was unable to provide evidence the personnel records for Staff A, B, and C, contained the required documentation.	S 200		
S 310	Residency Requirements 2.4.15.A Resident Records 2.4.15 (A) Resident Records A. Each residence shall, at a minimum, maintain the following information for each resident: 1. The resident's name; 2. The resident's last address; 3. The name of the person or agency referring the resident to the home; 4. The name, specialty (if any), telephone number, and emergency telephone number of each physician who is currently treating the resident; 5. The date the resident began residing in the home; 6. A list of medications taken by the resident, including dosage, and specific records of medication administration as required by the Department; a. In residences licensed at the M2 level, if a resident refuses to provide the information cited in § 2.4.15(A)(6) of this Part, this fact shall be documented in the resident's service		agreement. Facilities Regulation	

3 310

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S 310	Continued From page 3 7. Written acknowledgments that the resident has signed and received copies of the rights as provided in R.I. Gen. Laws§ 23-17.4-16; 8. Information about any specific health problems of the resident, which may be useful in a medical emergency, including diagnostic and/or therapeutic orders; 9. A record of personal property and funds which the resident has entrusted to the residence; 10. The name, address, and telephone number of a person identified by the resident who should be contacted in the event of an emergency or death of the resident and the name, address, and telephone number of the legal guardian; 11. Any other health-related emergency, or pertinent information which the resident requests the residence to keep on record; 12. A copy of the initial and periodic assessments described in§ 2.4.16 of this Part; 13. A copy of the service plan and nurse review as described in§ 2.4.16 of this Part; 14. A copy of the residency agreement as described in § 2.4.14(C) of this Part. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to include, at a minimum, information about any specific health problems of the resident, which may be	S 310		

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S 310	Continued From page 4 useful in a medical emergency, including diagnostic and/or therapeutic orders, for 2 of 4 residents receiving outside services, Resident ID #s 2 and 3. Findings are as follows: Following an entrance conference with the Administrator on 5/5/2025 at approximately 8:00 AM, a list of residents on outside services was provided to the surveyor. 1. Record review revealed Resident ID #2 moved into the residence in January of 2025 with diagnoses including, but not limited to, Vitamin D deficiency and unsteadiness on feet. Further record review revealed the resident was admitted to an outside agency for physical therapy **(PT)** services, beginning on 4/4/2025. Record review failed to reveal the outside agency service notes. During a surveyor interview on 5/5/2025 at approximately 1:00 PM with the Administrator, she acknowledged the resident record did not contain PT notes. 2. Record review revealed Resident ID #3 moved into the residence in April of 2023 with a diagnosis including, but not limited to: hemiparesis (muscle weakness on one side of the body) following a stroke. Further record review revealed the resident was admitted to an outside agency for physical therapy (PT) services, beginning on 3/29/2025. Record review failed to reveal outside agency	S 310	1. Resident ID#2 currently out of community. Resident ID#3 chart has been updated with the notes from PT. 2. Audit to be completed by 6/13/25 of all residents receiving third party services to ensure notes are present. 3. WD and/or designees will educate 3rd party providers on using the outside provider communication form by 6/13/25 to ensure notes are present in chart. 4. WD and/or designee will audit 25% of residents receiving outside services to ensure the outside communication form is being completed weekly x4 weeks, monthly x5 months, and reviewed in quarterly QA x6 months to monitor continued compliance.	

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S 310	Continued From page 5 service notes for the month of April. During a surveyor interview on 5/7/2025 at approximately 12:45 PM with the Administrator, she could not provide evidence of outside agency service notes for the above-mentioned residents.	S 310		
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	S 565		

Facilities Regulation

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S 565	Continued From page 6 pharmacy-dispensed container with proper label 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.	S 565		

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S 565	Continued From page 7 h. Individual medication records must be 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 one of two memory care medication carts and a medication cart for the second and third floor residents.	S 565		

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S 565	Continued From page 8 Findings are as follows: 1) Resident ID #4's Medication Administration Record indicates the resident is prescribed the following medications: - Acetaminophen 325 mg tablet. Take two tablets by mouth every 6 hours as needed. - Trazodone 50 mg tablet. Take a half tablet by mouth at bedtime (25 mg). During a surveyor observation of the memory care cart on 5/6/2025 at approximately 1:00 PM in the presence of Nurse, Staff D, the following was revealed: - The resident's Acetaminophen blister pack was labeled as Acetaminophen 325 mg tablet. Take 2 tablets by mouth every 4 hours as needed. - The resident had 2 Trazodone blister packs with differing instructions: a) Trazodone 50 mg tablet. Give ½ tablet by mouth at bedtime. Give ½ tablet by mouth twice/day as needed. b) Trazodone 50 mg tablet. Give ½ tablet by mouth at bedtime and every 8 hours as needed. During a surveyor interview with Staff D during the observations, she acknowledged the above medications did not have directions that matched the physician's orders. 2) During a surveyor observation of the medication cart for the second and third floor on 5/7/2025 at 11:00 AM in the presence of Certified Medication Technician (GMT), Staff E, the	S565	1. Direction change sticker added to acetaminophen and trazadone for resident ID#4 on 5/8/25 and audit completed on all of their meds same day to ensure blister pack and eMAR matched. 2. Fluticasone proprionate and benzonatate capsules were removed immediately. 3. WD and/or designee will complete house wide audit of all medications to ensure blister pack and eMAR match, and there are no expired medications present. To be completed by 6/20/25. 4. WD and/or designee will educate nurses and CMTs on the process of removing expired medications by 6/13/25. 5. WD and/or designee will educate nurses on the process to follow when there is a direction change to a medication by6/13/25. 6. WD and/or designee will audit 15% of resident medications for blister pack/eMAR accuracy and to ensure there are no expired medications present. Audits will be completed weekly x4 weeks, monthly x5 months. Results to be reviewed in quarterly QA x6 months to ensure compliance.	

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S 565	Continued From page 9 following was revealed: - A fluticasone propionate nasal spray bottle opened on 11/30/2024. Manufacturer instructions indicate to discard 6 weeks after opening. - 3 Benzonatate 100 mg capsules blister packs, with a discard date of 12/30/2024. During a surveyor interview with Staff E during the observations, she acknowledged the above medications were expired and should have been discarded.	S 565		
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	S 915	1. Meeting held with Dr. [redacted] and nurse practitioner [redacted] eld 5/29/25. Agreement established for either practitioner to be a part of the QA committee quarterly. 2. Q1 meeting minutes to be reviewed and signed by Dr. [redacted] and/or [redacted] by 6/6/25. 3. The previous Quarterly QA minutes/committee to be reviewed at Quarterly QA x24 months to maintain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01519	A. BUILDING: _____ B. WING	05/07/2025

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

(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 915	Continued From page 10 held in 2024 and the first quarter of 2025 failed to reveal a licensed physician, a certified nurse practitioner, or a licensed physician assistant in attendance. During a surveyor interview on 5/7/2025 at approximately 3:30 PM with the Administrator, she acknowledged a licensed physician, a certified nurse practitioner, or a licensed physician assistant were not in attendance as a member of the Quality Improvement Committee.	S 915		