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 10/28/2025

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, ACTS reference numbers 102333, 101406, 101491, 101899, 101916, 101945, 101946, 102026, and 102111, was conducted at this residence on 10/27/2025 through 10/28/2025 to determine compliance with state regulations. A deficiency was identified as a result of this survey.	S 003	The filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. This plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.	11/21/25
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 that the residence failed to provide all care and services in accordance with the prevailing community standard of care relative to physician's orders and blood pressure parameters for the singular resident reviewed for blood pressure medication, Resident ID #1. Findings are as follows: According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, "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	S 230	Received NOV 18 2025 Facilities Regulation 1. Resident ID 1 had medication d/c by PCP. 2. An house-wide audit of residents on blood pressure medications with parameters will be completed by 11/22/25. 3. In-service completed with all CMTs on medications with parameters and administration guidelines by 11/22/25. 4. Audit 100% of residents on blood pressure medicatons with parameters weekly x12 weeks, monthly x3 months. 5. WD/Designee will review quarterly x6 months to ensure maintained compliance.	

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	ALRA	11/16/25

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S 230	Continued From page 1 would harm the clients..." Review of a policy titled, "MEDICATION ADMINISTRATION," last revised 9/2023 states in part, "...All medications and treatments will be administered as prescribed...A...trained [medication technician]...may administer medications as directed by healthcare prescriber's orders...Staff administering medication must know or be able to locate medication information on the intended: purpose, side effects, dosage, and special instructions..." Record review of Resident ID #1 revealed a diagnosis including, but not limited to, hypertension (high blood pressure). This resident was reviewed due to a fall with injury on 9/20/2025. Review of the September 2025 Medication Administration Record (MAR) revealed an order for propranolol, 20 milligrams with instructions to administer twice daily but to hold the medication if the resident's systolic blood pressure (SBP, the top number in a blood pressure reading, which indicated the pressure in your arteries when your heart beats) is less than 120 and/or heart rate is less than 65. Further review of the September 2025 MAR revealed the following dates where the resident's propranolol was administered outside of the indicated blood pressure parameters: - 9/9 at 8:00 AM, with an SBP of 118 - 9/11 at 8:00 PM, with an SBP of 108 - 9/15 at 8:00 PM, with an SBP of 108 - 9/16 at 8:00 PM, with an SBP of 112 Review of the October 2025 MAR revealed the	S 230		

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S 230	Continued From page 2 following dates where the resident's propranolol was administered outside of the indicated blood pressure parameters: - 10/11 at 8:00 PM, with an SBP of 115 - 10/13 at 8:00 PM, with an SBP of 115 - 10/14 at 8:00 PM, with an SBP of 108 - 10/16 at 8:00 PM, with an SBP of 114 - 10/17 at 8:00 PM, with an SBP of 116 - 10/24 at 8:00 PM, with an SBP of 108 During a surveyor interview on 10/28/2025 at 10:04 AM, with Certified Medication Technician (CMT), Staff A, she revealed that the resident's propranolol should not be administered if the SBP is less than 120 and/or pulse is less than 65. Further, she revealed that she administered the resident his/her propranolol on 10/13/2025 at 8:00 PM and acknowledged that she should not have, as the resident's SBP was outside of the indicated parameter. During surveyor interviews on 10/27/2025 at 2:21 PM and 10/28/2025 at 8:15 AM, with the Executive Director and the Director of Wellness, they revealed that it is their expectation that CMTs follow the physician's orders. They acknowledged the resident's propranolol was administered on the above dates and times in September and October, and indicated that it should have been held, per the physician's order.	S 230		