RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01484	A. BUILDING: _____ B. WING _____	05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERMAIN MANOR/WOONSOCKET HOUSIN	429 EAST SCHOOL ST WOONSOCKET, RI 02895

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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	RECEIVED JUN 13 2023 FACILITIES REGULATION	
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 residence's criteria for residency.	S 360	6/21/23	6/9/23

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David Kanlian — TITLE: Administrator — (X6) DATE: 6/6/23

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S 360	Continued From page 1 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 record review and staff interview, it has been determined the residence's assessment form failed to report appropriate information of the resident's needs related to medication self-administration for 1 of 3 sample residents reviewed, Resident ID #2. Findings are as follows Record review for the resident revealed s/he moved into the residence in February of 2022 with diagnosis including diabetes. Record review revealed the resident has a physician order to self-administer his/her Lantus insulin daily. Further record review of a comprehensive assessment dated 11/22/2022 failed to reflect the resident is self-administering his/her insulin as ordered. During a surveyor interview on 5/23/2023 at 1:50 PM with the Director of Wellness, she acknowledged the resident self-administers his/her insulin as ordered. She further acknowledged the resident's comprehensive assessment did not report self-administration of insulin.	S 360	**S 360** **Corrective Measure:** To fix the deficient practice resident ID#2, All updates have been updated in the resident appendix C to reflect she/he is capable of self administration of medications. **Identification of residents:** For those residents having the potential of being affected by the same deficient practice, the resident care director has reviewed all residents who self-administer medications and has confirmed that all residents that self-medicate are capable and have been updated in the appendix C if needed. **Preventative Measure:** To ensure that the deficient practice does not recur, every 90 days the resident care director will verify that residents who do their own medications have been updated in the service plan and appendix C. **Monitoring:** To monitor that the deficient practice does not recur, every 90 days at the quarterly Quality Improvement Meeting the resident care director will verify that all residents that do their own medication is included in the resident's appendix C upon move in and significant change.	

6/21/23

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S 490	Continued From page 2	S 490		
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. Findings are as follows: Record review of section 4-501.112 of the Rhode Island Food Code edition 2018 states in part, "Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures. (A)...the temperature of the fresh hot water sanitizing rinse as it enters the manifold may not be more than 90 [degrees] F [Fahrenheit], or less than:...(2) For all other machines, 82 [degrees] C (180 [degrees] F)..." During an initial tour of the kitchen on 5/23/2023 at 7:30 AM revealed the following: 1) dish room: the hot water dish machine reached a temperature of 176 degrees Fahrenheit for four out of the five times obseved which is 4 degrees less than the required temperature neeeded for sanitizing.	S 490	**S 490** **Corrective Measure:** To fix the deficient practice the FSM has taken the dishwasher offline and then was repaired by Marshall Electric **Identification of residents:** N/A CM 6/21/23 **Preventative Measure:** To ensure that the deficient practice does not recur, daily the dining services will check the temperature of dish machine to unsure it is coming. to temperature. In the event of low temperature the dish machine will be taken offline until repaired. **Monitoring:** To monitor that the deficient practice does not recur, every 90 days at the quarterly Quality Improvement Meeting the FSM will verify that the dish washer has been completed daily. the FSM will provide the committee with documentation verifying her findings at the quarterly QI.	

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S 490	Continued From page 3 During a follow up visit to the kitchen on 5/23/2023 at 11:45 AM, the dish machine failed to reach the appropriate hot water temperature after testing it five more times. The water temperature reached 176 degrees Fahrenheit during this observation. During a surveyor interview with the Food Service Director, FSD, on 5/23/2023 at approximately 11:50 AM, she acknowledged the dish machine was not reaching 180 degrees F for proper sanitization. She further acknowledged that the dish machine temperature strip log was last monitored on 5/7/2023. 2) the dry storage area revealed the following expired items: - Four 1- gallon containers of sweet relish with a pack date of 9/12/2022 and a best use by date of 3/11/2023. One of the containers was leaking. - A jar of basil pesto with an expiration date of 1/18/2023. - A box of chick pea pasta best used by 3/9/2022 - A 15 oz jar of cheese whiz best used by 6/30/2022. During a surveyor interview immediately following the above observation with the FSD, she acknowledged the foods items were expired and needed to be discarded.	S 490	**S 490** **Corrective Measure:** To fix the deficient practice the FSM has disposed of all expired products and has contacted purveyor of the expired products delivered. **Identification of residents:** N/A **Preventative Measure:** To ensure that the deficient practice does not recur, upon delivery the FSM will Verify that products have not exceeded the best by date and monthly the FSM will inspect dry storage for expired products. **Monitoring:** To monitor that the deficient practice does not recur, every 90 days at the quarterly Quality Improvement Meeting the FSM will verify that a monthly inspection has been conducted to ensure that dry goods have not reached expiration.	
S 705	Physical Plant 2.4.30(I) Safety Requirements 2.4.30 (I) Safety Requirements	S 705		

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S 705	Continued From page 4 I. Each residence shall develop and maintain a written plan and procedure for the evacuation of 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:	S 705	**S 705** **Corrective Measure:** Effective immediately fire drills have been performed to meet 50 percent obstructed and forms have been updated to include end time. **Identification of residents:** N/A **Preventative Measure:** To ensure that the deficient practice does not recur, the Administrator will perform a fire drill on a bimonthly basis with 50 being obstructed. **Monitoring:** To monitor that the deficient practice does not recur, every 90 days at the quarterly Quality Improvement Meeting the Administrator will verify that fire drills have been completed on a bimonthly basis.	

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S 705	Continued From page 5 (1) Name of the person conducting the drill; (2) Date and time of the drill; (3) Amount of time taken to evacuate the 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 the residence failed to ensure drills simulating fire emergencies, testing the effectiveness of the fire evacuation plan 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, and 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). Findings are as follows: Record review revealed fire drills were conducted on the following dates: 3/8/2022, 4/14/2022, 4/19/2022, 8/2/2022, 9/14/2022, 10/6/2022,	S 705		

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S 705	Continued From page 6 10/25/2022, 1/17/2023, 2/3/2023 and 4/18/2023. Further record review revealed obstructed drills were conducted on 8/2/2022 and 2/3/2023 which is 20% of the drills instead of 50% as required. Additional record review of fire drill documentation from the above-mentioned dates failed to include the amount of time taken to evacuate the building or unit as required. During an interview on 5/23/2023 at 2:45 PM with the Administrator, he acknowledged the fire drills did not meet the required 50% of obstructed drills conducted. Additionally, he could not provide evidence as to why the fire drill documentation did not include the amount of time it takes to evacuate the building or unit as required.	S 705		