RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01468	A. BUILDING: _____ B. WING _____	05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA LINCOLN PLACE	612 GEORGE WASHINGTON HIGHWAY LINCOLN, RI 02865

(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	S003: Preparation, execution, and submission of this Plan of Correction does not constitute an admission of fault or liability on the part of Atria Lincoln Place nor agreement by Atria Lincoln Place as to the truth of the facts alleged or conclusions drawn in the Statement of Deficiencies or any specific statement of non-compliance. Atria Lincoln Place prepares and submits this Plan of Correction to comply with state laws and regulatory provisions.	
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 care and services in accordance with prevailing community standards of care relative to fall risk safety for one resident reviewed, ID #1. Findings are as follows: According to the National Library of Medicine, "Falls in older adults are a major public health concern often resulting in longstanding pain, functional impairment, disability, premature nursing home admission, increased length of stay in hospitals, and mortality." Record review revealed ID #1 was admitted to the residence in March of 2022 with diagnoses	S 230	S230: Organization and Management 2.4.13 (A/B) Management of Services	

RECEIVED
JUN 16 2023
FACILITIES REGULATION

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 6/15/2023

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S 230	Continued From page 1 including, but not limited to: depression, hypertension, and cognitive impairment. Record review of ID #1's nurse reviews dated 01/05/2023 and 04/06/2023 reveal falls on the following dates: -10/26/2022 -11/19/2022 -03/26/2023 -03/27/2023 -03/38/2023 -04/12/2023 Record review revealed a plan to "continue to supervise transfers and mobility due to high risk for falls." The records fails to reveal notification to his/her primary care doctor or recommendations for physical therapy. During an interview on 05/22/2023 at approximately 4:10 PM, the Resident Service Director acknowledge ID #1 had several falls with no documented care coordination for prevention.	S 230	S230: Records show fax notice to the PCP for falls on 3/26, 3/27, 3/28 and 4/13 with no corresponding response. Following any fall, Resident Services Director to confirm notification to the PCP and Root Cause Analysis are completed in a timely manner. S230: Regional Care Director to retrain Resident Services Director to the requirements of Atria Work Instruction titled Assessment Process - Root Cause Analysis and the requirements of 2.4.13 (A/B) Management of Services. S230: Responsibility for compliance is the responsibility of the Resident Services Director or designee. Executive Director will audit weekly, for the next 90 days, to ensure compliance.	7/15/2023 9/15/2023
S 365	Residency Requirements 2.4.16.D Resident Assessment/Service Plans 2.4.16 (d) Resident Assessments and Service Plans D. The assessment shall be reviewed and at intervals not to exceed twelve (12) months and each time a resident's condition changes significantly.	S 365		

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S 365	Continued From page 2 This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to review the resident's comprehensive assessment at intervals not to exceed (12) months and each time a resident's condition changes significantly for two of five sample residents, ID #s 1 and 2. Findings are as follows: Review of a list of residents receiving outside services provided by the Executive Director on 05/22/2023 indicated ID #1 is receiving hospice services and ID #2 is receiving skilled nursing services from an outside agency for wound care. 1) Record review revealed ID #1 was admitted to the residence in March of 2022 with diagnoses including, but not limited to: depression, hypertension, and cognitive impairment. Record review of ID #1's "outside agency form" entries revealed the following: -04/21/2023: "Wound assessment left lateral calf" -05/02/2023: "Wound care left shin" -05/09/2023: "Wound care, d/c (discharge) today" Record review of nursing notes revealed on 03/13/2023 "...skin tear left forearm, evaluation for wound care ongoing..." Documentation failed to reveal a wound care evaluation or wound care notes for the Resident's left forearm. The record revealed ID #1's last comprehensive assessment to be dated 07/22/2022, failing to reveal the assessment was updated to reflect the outside skilled nursing services beginning 03/13/2023 and ongoing for wound care.	S 365	S365: Residency Requirements 2.4.16(D) Resident Assessment/Service Plans S365: Resident Service Director/designee will complete an audit of Comprehensive Resident Assessments to ensure resident assessments accurately reflect current required services. S365: Resident Services Director to complete Comprehensive Assessment for Change of Condition for ID #1.	7/15/2023 6/30/2023

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S 365	Continued From page 3 2) Record review revealed ID #2 was admitted to the residence in January of 2020 with diagnoses including, but not limited to: chronic kidney disease, cardiomyopathy, and seizure disorder. A hospice coordination note dated 01/25/2023 indicates ID #2 was "admitted to hospice services...requires ongoing skilled intervention to support goal of comfortable death in setting of choice." The record revealed ID #2's last comprehensive assessment to be dated 12/29/2022, failing to reflect the assessment was updated to reflect hospice services that began on 01/25/2023. During an interview on 05/22/2023 at approximately 4:00 PM, the Resident Services Director was unable to provide evidence Resident ID #s 1 and 2's assessments had been updated as required and acknowledged that the documentation of outside services was insufficient.	S 365	S365: Resident Services Director to complete Comprehensive Assessment for Change of Condition for ID #2. S365: Regional Care Director to retrain Resident Services Director and nursing staff on the requirement to have accurate and up to date comprehensive assessments. S365: Responsibility for compliance is the responsibility of the Resident Services Director or designee. Comprehensive Assessments will be completed Annually and on Change of Condition. Executive Director will audit weekly, for the next 90 days, to ensure compliance.	6/30/2023 7/15/2023 9/15/2023
S 545	Resident Care Services 2.4.24.A.1 Medication Services 2.4.24 (A) Medication Services 1. For M1 and M2 licensure levels, each resident shall have the right to: a. Retain the services of his/her own personal physician and dentist; b. Select the pharmacy or pharmacist of his/her choice provided that the pharmacy or pharmacist supplies medications suitably packaged for the residence's program;	S 545		

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S 545	Continued From page 4 c. Refuse any or all medications; d. Retain possession and control of his/her medications, provided that such possession and control is deemed safe by the resident, the resident's guardian, if appropriate, and the administrator or his/her designee in consultation with the resident's physician(s). This Requirement is not met as evidenced by: Based on observation, record review, and staff interview it has been determined the facility failed to ensure a resident who retains their medication was deemed safe by the resident, the resident's guardian, if appropriate, and the administrator or his/her designee in consultation with the resident's physician for one out of five sample residents reviewed, ID #3. Findings are as follows: Record review of ID #3's comprehensive assessment dated 08/15/2021 reveals, "no longer does meds due to visual impairment." Record review of ID #3's service plan dated 01/26/2023 reveals, "requires oxygen with exertion." Record review of medication list fails to reveal oxygen. Record review of ID #3's assessments failed to reveal an assessment for the self-administration of oxygen. During an exit interview on 05/22/2023 at approximately 4:05 PM, the Resident Services	S 545	S545: Resident Care Services 2.4.24.A.1 Medication Services S545: Resident Services Director to complete Comprehensive Assessment for Change of Condition according to physician's order specific to medication management of Oxygen for ID #3. S545: Resident Services Director to ensure ID #3 medication list evidences Oxygen. S545: Resident Services Director to complete a Self-Management of Oxygen Assessment for ID#3. (Last assessment done on 3/15/2023.)	6/22/2023 6/22/2023 6/22/2023

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S 545	Continued From page 5 Director acknowledged that oxygen was not listed on the resident's medication list, and that the resident had not had a self-administration of medication assessment.	S 545		