RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01501	A. BUILDING: _____ B. WING _____	05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPEL HILL	10 OLD DIAMOND HILL ROAD CUMBERLAND, RI 02864

(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 and a complaint/incident investigation survey (HHCL11, 05/24/2023 through 5/25/2023) were conducted at this residence. Deficiencies were identified relative to the State Licensure survey.	S 003		
S 075	Licensure Requirements 2.4.5(A) Safe Resident Handling 2.4.5 (A) Safe Resident Handling A. Each licensed assisted living residence with an "Alzheimer ' s Dementia Special Care Unit or Program" license and/or offers to provide or provides coordination of hospice services for residents who are bed-bound or in need of assistance from more than one staff person for ambulation shall comply with the provisions of §§ 2.4.5(B) through (E) of this Part as a condition of licensure. 1. Notwithstanding the requirements of § 2.4.5(A) of this Part, assisted living residences licensed for an "Alzheimer ' s Dementia Special Care Unit or Program" prior to 1 June 2015 shall be in compliance with the requirements of §§ 2.4.5(B) through (E) of this Part not later than 1 July 2015. 2. A currently licensed assisted living residence who applies for a new level of licensure on or after 1 June 2015 will be required to meet the requirements of §§ 2.4.5(B) through (E) of this Part prior to a new license level being approved. This Requirement is not met as evidenced by: Based on record review and staff interview, the residence with an "Alzheimer's Dementia Special Care Unit or Program" license failed to ensure there was a Safe Resident Handling program which complies with the provisions of §§ 2.4.5(B)	S 075	RECEIVED JUN 21 2023 FACILITIES REGULATION The Safe Resident Handling Committee has been created by DOW and RCC in conjunction with Fox Rehab. The staff will be in-serviced on the Safe Resident Handling Policy and a calendar has been created for the year. A Safe Resident Handling meeting was held on 6/9 and 6/14 to review any staff/resident injuries over the last quarter and minutes have been recorded. An Audit of all MC residents charts to ensure there is a Safe Resident assessment present. The audit will be completed 6/16 by DOW or designee. An audit will be completed on 10% of MC residents weekly every four weeks then monthly for six months. Audits will be reviewed in QA every three months to ensure compliance. All Safe Resident Handling in-servicing will be completed by 6/30/2023.	

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

Christine M Shea

6/21/2023

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S 075	Continued From page 1 through (E) as a condition of licensure. Findings are as follows: The residence failed to produce evidence there was an established Safe Resident Handling program which included the following components as referenced in the provisions of §§ 2.4.5(B) through (E): - Maintain a safe resident handling committee, chaired by a professional nurse or other appropriate licensed health care professional with at least half of the members of the committee being hourly, non-managerial employees who provide direct resident care. - A written safe resident handling program, with input from the safe handling committee, to prevent musculoskeletal disorders among health care workers and injuries to residents. As part of this program, each licensed assisted living shall: 1) Implement a safe resident handling policy for all shifts and units 2) Conduct a resident handling hazard assessment 3) Develop a process to identify the appropriate use of the safe resident handling policy based on the resident's physical and mental condition, the resident's choice, and the availability of lifting equipment or lift teams 4) Designate and train a registered nurse or other appropriate licensed health care professional to serve as an expert resource, and train all direct care staff on safe resident handling policies, equipment, and devices before implementation, and at intervals not to exceed twelve (12) months, or as changes are made to the safe handling	S 075		

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S 075	Continued From page 2 policies, equipment and/or devices being used 5) Conduct a performance evaluation of the safe resident handling policy at intervals not to exceed twelve (12) months, with the results of the evaluation reported to the safe resident handling committee or other appropriately designated committee During an interview on 5/25/2023 at approximately 12:10 PM, with the Regional Nurse, she acknowledged the residence failed to; established a Safe Resident Handling program, implement a Safe Resident Handling policy, conduct meetings of the Safe Resident Handling committee, assess individual residents in regards to Safe Resident Handling, or conducted a facility wide Safe Resident Handling evaluation at intervals not to exceed twelve (12) months as required.	S 075		
S 315	Residency Requirements 2.4.15(B) Resident Records 2.4.15 (B) Resident Records B. Entries in the resident's record relating to treatment, medication and diagnostic tests shall be made by the responsible persons at the time of administration and/or service. Only physicians shall enter or authenticate medical opinions or judgment. 1. Detailed descriptions of all pressure ulcers, or other skin lesions, shall be recorded in the resident's record. This Requirement is not met as evidenced by: Based on record review and staff interview it has	S 315	Resident record #7 is updated to reflect wound and care provided by outside agency. Audit of all residents charts receiving outside services have been updated for accuracy. Nursing staff in-serviced on Wound Documentation and documentation on all services provided by outside agency. An audit will be completed on 10% of residents receiving outside services for accuracy weekly for four weeks and monthly for six months and at QA for nine months.	

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S 315	Continued From page 3 been determined that the residence failed to provide detailed descriptions of all pressure ulcers, or other skin lesions, in the resident's record for one of one residents reviewed for wound care, Resident ID #7. Findings are as follows: Record review revealed that Resident ID #7 was admitted to the facility in December of 2020 with diagnosis including but not limited to dementia and anxiety. Record review revealed the resident was receiving wound care provided by an outside agency from April of 2023 through May of 2023. Record review for Resident ID #7 failed to reveal detailed descriptions of his/her wounds (located on his/her buttocks and left shin) that were being followed by an outside agency on the following dates: -4/13/2023 -4/17/2023 -4/20/2023 -4/28/2023 -5/1/2023 -5/4/2023 -5/10/2023 During a surveyor interview on 5/25/2023 at approximately 12:50 PM with the Regional Nurse, she was unable to provide evidence of detailed descriptions for all skin lesions for Resident ID #7.	S 315	months for compliance.	
S 375	Residency Requirements 2.4.16(F) Resident Assessment/Service Plans	S 375		

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S 375	Continued From page 4 2.4.16 (F) Nurse Review 1. Nurse review is necessary for all levels of licensure. a. A registered nurse shall visit the residence at least once every thirty (30) days except as provided in § 2.4.16(F)(1)(b) of this Part and shall complete a review to include the following: (1) Monitor the medication regimen for all residents; (2) Review any new physician orders and evaluate the health status of all residents by identifying symptoms of illness and/or changes in mental/physical health status; (3) Evaluate the appropriateness of placement for each resident; (4) Make any necessary recommendations to the administrator; (5) Follow up on previous recommendations; (6) Provide a signed, written report in the residence documenting: (AA) Date and time of assessment; (BB) Recommendations for follow-up; (CC) Progress on previous recommendations; (DD) Verification that the medication listed by the pharmacist on the mediset, blister pack or medication container is current with physician orders (M-1 level only); (EE) Physical assessment identifying symptoms of illness and/or changes in mental or physical health status and appropriateness of placement; (FF) Such reports shall be on file at the residence.	S 375	Residents #1,2,5,6 &7 charts have been updated and nurse review completed. Nurse review updated in PCC to ensure all components present to meet regulation. 90-day nurse review will be completed in PCC going forward and will meet regulatory guidelines. An Audit of 10% of resident assessments will be completed weekly for four weeks then monthly for six months. Audit will be reviewed in quarterly for nine months QA meeting to ensure compliance .	

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S 375	Continued From page 5 (7) Complete the quarterly evaluation of the residence's registered medication aide(s) administration of medication. (Approved Department form is available for downloading online). b. In those residences that have one or more licensed registered nurses (i.e., at least one full-time equivalent equal to thirty-five (35) hours) on- site, the nurse review shall be completed at least once every ninety (90) days. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to ensure that nurse reviews contain all required components for five of eight sampled residents, Resident ID#s 1, 2, 5, 6, and 7. Findings are as follows: 1) Review of the quarterly nurse review completed on 5/4/2023 for Resident ID #1 failed to reveal evidence that it included any new physician orders, evaluation of the health status of all residents by identifying symptoms of illness and/or changes in mental/physical status, follow up on previous recommendations, and verification that the medication listed by the pharmacist on the mediset, blister pack or medication container is current with physician orders. 2) Review of the quarterly nurse review completed on 3/11/2023 for Resident ID #2 failed to review evidence that it included any new physician orders, evaluation of the health status of all residents by identifying symptoms of illness and/or changes in mental/physical status, follow up on previous recommendations, and	S 375		

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S 375	Continued From page 6 verification that the medication listed by the pharmacist on the mediset, blister pack or medication container is current with physician orders. 3) Review of the quarterly nurse review completed on 3/2/2023 for Resident ID #5 failed to review evidence that it included any new physician orders, evaluation of the health status of all residents by identifying symptoms of illness and/or changes in mental/physical status, follow up on previous recommendations, and verification that the medication listed by the pharmacist on the mediset, blister pack or medication container is current with physician orders. 4) Review of the quarterly nurse review completed on 4/5/2023 for Resident ID #6 failed to review evidence that it included any new physician orders, evaluation of the health status of all residents by identifying symptoms of illness and/or changes in mental/physical status, follow up on previous recommendations, and verification that the medication listed by the pharmacist on the mediset, blister pack or medication container is current with physician orders. 5) Review of the quarterly nurse review completed on 3/2/2023 for Resident ID #7 failed to review evidence that it included any new physician orders, evaluation of the health status of all residents by identifying symptoms of illness and/or changes in mental/physical status, follow up on previous recommendations, and verification that the medication listed by the pharmacist on the mediset, blister pack or medication container is current with physician orders.	S 375		

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S 375	Continued From page 7 During a surveyor interview on 5/25/2023 at 10:00 AM with the Director of Health and Wellness and the Wellness Coordinator they acknowledged that the nurse reviews completed for Resident ID#s 1, 2 , 5, 6, and 7 did not contain all of the required components of the nurse review.	S 375		
S 385	Residency Requirements 2.4.16(G)(2) Resident Assessment/Service Plan 2.4.16 (G)(2) Service Plans 2. The service plan shall be developed by a registered nurse and/or the certified assisted living residence administrator, and shall be signed, approved, and dated by both parties. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined the residence failed to ensure that the service plan shall be reviewed each time a resident's condition changes significantly for one of six sampled residents reviewed for service plans, Resident ID #6. Findings are as follows: Per the Rules and Regulations for Licensing Assisted Living Residences a significant change is defined in part as "means an improvement or decline in the resident's health status..." Record review for Resident ID #6 revealed s/he moved into the residence on 4/30/2013 with a diagnosis to include but not limited to diabetes mellitus. The resident had a hospital and rehabilitation stay	S 385	Service plan for resident #6 updated to reflect COC. Nursing Staff will be in-serviced on change of condition and updating service plans as appropriate. ED or designee will review all COC assessments/service plans weekly X 4 weeks then monthly x 6 months. Audit of assessments and service plans will be reviewed in QA x 9 months.	

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S 385	Continued From page 8 from 4/27/2023 through 5/20/2023 for frequent falls and a diagnosis that included human metapneumovirus pneumonia (a respiratory disease that affects people with weakened immune systems). Review of a change of condition assessment dated 5/20/2023 reveals s/he was assessed as needing assistance for bowel incontinence which includes assistance in peri care. Review of a service plan that was updated on 5/20/2023 for Resident ID #6 failed to reveal evidence that it reflected the change in the resident's condition related to his/her bowel incontinence and the need for peri care. During a surveyor interview on 5/25/2023 at approximately 1:00 PM with the Wellness Coordinator she revealed that prior to his/her hospitalization and stay in a skilled rehabilitation facility, Resident ID #6 was continent of bowel. Upon his/her return to the facility s/he is incontinent of bowel and the staff is providing him/her with peri care. Additionally, she acknowledged the change in condition was not reflected in his/her service plan.	S 385		
S 450	Licensure Requirements 2.4.18 Rights of Residents 2.4.18 Rights of Residents A. Every assisted living residence for adults licensed pursuant to these regulations shall observe the standards stated in R.I. Gen. Laws § 23-17.4-16, "Rights of Residents" and such other appropriate standards as may be prescribed in rules and regulations promulgated by the	S 450		

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S 450	Continued From page 9 Department with respect to each resident of the residence. B. For purposes of the following standards stated in §§ 2.4.18(B)(1) through (7) of this Part the term "resident" shall also mean the resident's agent as designated in writing or legal guardian. 1. Upon request have access to all records pertaining to the resident, including clinical records, within the next business day or immediately in emergency situations; 2. Upon admission and during the resident's stay be fully informed in a language the resident understands, of all resident rights and rules governing resident conduct and responsibilities; a. Each resident shall receive a copy of their rights. b. Each resident shall acknowledge receipt in writing; and c. Each resident shall be informed promptly of any changes. 3. Be informed in writing, prior to, or at the time of admission or at the signing of a residential contract or agreement of: a. The scope of the services available through the residence's service program, including health services, and of all related fees and charges, including charges not covered either under federal and/or state programs by other third party payers or by the residence's basic rate; b. The residence's policies regarding overdue	S 450 6/21/23	Resident roster has been removed from Survey binder. In-service held with staff 6/14 on Resident's Rights and ongoing education.	

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S 450	Continued From page 10 payment including notice provisions and a schedule for late fee charges; c. The residence's policy regarding acceptance of state and federal government reimbursement for care in the residence both at time of admission and during the course of residency if the resident depletes his or her own private resources; d. The residence's criteria for occupancy and termination of residency agreements; e. The residence's capacity to serve residents with physical and cognitive impairments; f. Support any health services that the residence includes in its service package or will make appropriate arrangements to provide these services; 4. Upon provision of at least thirty (30) days notice, if a resident chooses to leave a residence, the resident shall be refunded any advanced payment made provided that the resident is current in all payments; 5. The residence can discharge a resident only for the following reasons and within the following guidelines: a. Except in life-threatening emergencies and for nonpayment of fees and costs, the residence gives thirty (30) days' advance written notice of termination of residency agreement with a statement containing the reason, the effective date of termination, the resident's right to an appeal under state law, and the name/address of the State Ombudsperson's office;	S 450		

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S 450	Continued From page 11 b. If resident does not meet the requirements for residency criteria stated in the residency agreement or requirements of state or local laws or regulations; c. If resident is a danger to self or the welfare of others; and the residence has attempted to make a reasonable accommodation without success to address resident behavior in ways that would make termination of residency agreement or change unnecessary; which would be documented in the resident's records; d. For failure to pay all fees and costs stated in the contract, resulting in bills more than thirty (30) days outstanding. A resident who has been given notice to vacate for nonpayment of rent has the right to retain possession of the premises, up to any time prior to eviction from the premises, by tendering to the provider the entire amount of fees for services, rent, interest, and costs then due. The provider may impose reasonable late fees for overdue payment; provided that the resident has received due notice of such charges in accordance with the residence's policies. Chronic and repeated failure to pay rent is a violation of the lease covenant. However the residence must make reasonable efforts to accommodate temporary financial hardship and provide information on government or private subsidies available that may be available to help with costs; and e. The residence makes a good faith effort to counsel the resident if the resident shows indications of no longer meeting residence criteria or if service with a termination notice is anticipated;	S 450		

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S 450	Continued From page 12 6. To be able to share a room or unit with a spouse or other consenting resident of the residence in accordance with terms of the resident contract; 7. To live in a safe and clean environment. C. In addition to the standards stated in R.I. Gen. Laws § 23-17.4-16, residents are entitled to the following: 1. Receive dental services from a dentist of his/her choice; 2. Each resident shall be given, in writing, the names, addresses, and telephone numbers of: the Department; the Medicaid Fraud and Patient Abuse Unit of the Department of Attorney General; the State Ombudsperson; and local police offices. D. The residence must: 1. Implement written policies and procedures to ensure that all residence employees are aware of and protect the resident's rights contained in these regulations; 2. Have prominently displayed a posting of the most recent state licensing survey of the assisted living residence; and 3. Provide each resident or his or her representative upon admission, a copy of the provisions of § 2.4.18 of this Part and shall display in a conspicuous place on the premises a copy of the "Rights of Residents."	S 450		

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S 450	Continued From page 13 This Requirement is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined the residence failed to implement written policies and procedures to ensure that all of the residence's employees protect the resident's rights contained in these regulations and to observe the standards stated in R.I. Gen. Laws § 23-17.4-16 (a)(2)(ix) relative to identifying information for 2 residents listed in the facility's survey results binder located in the main lobby. Findings are as follows: During a surveyor observation on 5/25/2023 at approximately 10:30 AM of the residence's lobby area revealed a binder which included documents relative to the most recent state licensing survey of the assisted living residence. Located in this binder were two Resident/Staff Roster forms dated 1/25/2023 and 8/30/2022 with two resident identifiers. During a surveyor interview on 5/25/2023 at 10:37 AM with the Regional Nurse, she acknowledged the resident identifiers and removed the rosters. During a surveyor interview on 5/25/2023 at 12:34 PM with the Wellness Coordinator, she acknowledged two resident names were posted in the binder located in the main lobby and should not have been.	S 450		
S 490	Residential Care Services 2.4.21(C) Dietetic Services 2.4.21 (C) Dietetic Services	S 490		

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	ALR01501	A. BUILDING: _____ B. WING _____	05/25/2023

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S 490	Continued From page 14 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 observations 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: 1. The Rhode Island Food Code 2018 Edition 2-402.11 reveals in part, "...food employees shall wear hair restraints, beard restraints that are designed and worn to effectively keep their hair from contacting exposed food..." During a surveyor observation on 5/24/2023 at approximately 10:00 AM, the Dining Service Director (DSD), was observed in the main kitchen preparing peppers and onions without a beard restraint. Further observation on 5/24/2023 at approximately 12:15 PM, revealed Care Partner, Staff A, was observed without a hair restraint while serving food from the steam table in the memory care unit kitchenette. 2. The Rhode Island Food Code 2018 Edition 4-601.11 states in part,"...nonfood contact surfaces of equipment shall be kept free of an accumulation of dirt...and other debris..."	S 490 S 490 6/21/23	All staff have been in-serviced on hair/beard nets need and location for any employee entering the kitchen. This includes employees serving on the MC unit . Audits will be conducted every week for four weeks then monthly for six months and then at QA for nine months.	

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S 490	Continued From page 15 During a surveyor observation of the main kitchen on 5/24/2023 at approximately 10:00 AM, the circulation system of the juice dispensing system was observed to have a high accumulation of dust build up. Further surveyor observation of the main kitchen on 5/24/2023 at approximately 10:00 AM, in the dish room area, a fan in the window located above the clean side of the dish machine was observed to have a high accumulation of dust build up blowing dust particles on clean dishes and utensils. 3. The Rhode Island Food Code 2018 Edition 3-501.19 reads in part, "...The food shall have an initial temperature...57 degrees C (135 degrees Fahrenheit) when removed from hot holding temperature controls..." During surveyor observation on 5/24/2023 at approximately 12:15 PM in the memory care unit kitchenette, hamburger patties that were an alternate lunch meal selection had a temperature reading of 120 degrees Fahrenheit. 4. The Rhode Island Food Code 2018 Edition 3-304.11 reads in part,"...food shall only contact surfaces of equipment and utensils that are cleaned...and sanitized..." During a surveyor observation on 5/24/2023 at approximately 12:15 PM in the memory care unit kitchenette, Staff A was observed taking temperatures of the meal choices that were being served for lunch that included hamburger patties, hot dogs, and pork quesadillas without sanitizing the thermometer probe between each use. An additional surveyor observation of the main	S 490	Kitchen fans have been vacuumed and washed and are dust free. A schedule has been put into place for semi-annual cleaning of kitchen fans. All staff have been in-serviced in serving meals and temperature reading. All staff will sanitize meat thermometers between uses. Audits will be conducted weekly for four weeks then monthly for six months and reviewed quarterly in QA for 12 months.	

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S 490	Continued From page 16 kitchen on 5/24/2023 at approximately 12:20 PM, the DSD was observed taking temperatures of hamburger patties, hot dogs, and pork quesadillas without sanitizing the thermometer probe between each use. 5. The Rhode Island Food Code 2018 Edition 3-501.16 reads in part,"....Time/Temperature Control for Safety Food, Hot and Cold Holding...for safety food shall be maintained...at 5 degrees C (41 degrees Fahrenheit)..." During a surveyor observation on 5/24/2023 at approximately 9:30 AM in the dining room, individually packets of butter were observed on the dining room table. During a surveyor observation of the walk-in refrigerator unit in the main kitchen on 5/24/2023 at approximately 10:00 AM, a case of butter packets was observed with labeling that read in part "...keep refrigerated." During a surveyor interview on 5/24/2023 at approximately 11:45 with a Waitstaff team member, Staff B, she revealed the butter packets had been on the dining room tables since breakfast which begins at approximately 7:30 AM. Additionally she revealed they had not been refrigerated between meal services. 6. The Rhode Island Food Code 2018 Edition 7-209.11 reads in part employees shall store their personal items in facilities as specified under 6-305-1 which reads in part,"...locker or other suitable facilities shall be provided for the orderly storage of employee's clothing or possessions..." During a surveyor observation on 5/24/2023 at approximately 10:00 AM of the main kitchen, a	S 490	Audits will be conducted weekly for four weeks then monthly for six months. Audit will be reviewed in QA for nine months. Staff has been in-serviced to place all butter packets in the refrigerator in between meal services. All staff have been in-serviced to leave their personal belongings in their car or in the break-room lockers. Audits will be conducted weekly for four weeks then monthly for six months. Audit will be reviewed in QA for nine months	

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S 490	Continued From page 17 cell phone and a lanyard were observed sitting on top of a stack of white dishes and an orange bandana was lying on a stainless-steel worktable behind the conveyor toaster. 7. During a surveyor observation on 5/24/2023 at approximately 10:15 AM of the main kitchen, a quart container of lactaid fat free milk was observed and a ¼ inch pan with raw white fish fillets both with a use by dates of 5/18/2023. During a surveyor interview on 5/24/2023 at approximately 10:30 AM with the DSD on the facility policy for food storage he revealed that food should be discarded three days from opening and preparation. Additionally he acknowledged that the lactaid milk and fish with the use by date of 5/18/2023 should have been discarded. During a surveyor interview on 5/25/2023 at approximately 11:00 AM with the DSD, he acknowledged staff members were not wearing hair restraints, food was being stored beyond the facility policy of three days, personnel items were being stored in the main kitchen, holding temperatures were not within the acceptable hot holding parameters and the butter packets on the dining room tables were not refrigerated.	S 490		
S 590	Residential Care Services 2.4.25(C) Recreational And Other Services 2.4.25 (C) Residential Care Services C. Personal assistance shall be provided as necessary, pursuant to the provisions of § 2.3(A)(29) of this Part and shall consist of activities such as bathing, oral hygiene, fingernail care,	S 590		

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S 590	Continued From page 18 shampooing, shaving, dressing or assistance with ambulation or nutrition and hydration. 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 provide personal assistance as necessary, pursuant to the provisions of §2.3(A)(29) of this part and shall consist of activities such as, dressing for 1 of 8 residents reviewed related to attire, Resident ID #7. Findings are as follows: Record review revealed that Resident ID #7 was admitted to the facility in December of 2020 with diagnoses including but not limited to dementia and anxiety. Record review revealed a service plan date 10/6/2022 which reveals the resident will be dressed appropriately with the assistance of care staff and that the resident requires moderate assistance for dressing and undressing. During multiple surveyor observations on 5/24/2023 the resident was observed wearing a hooded sweatshirt with an orange stain on the collar of the sweatshirt and gray cotton sweatpants. During multiple surveyor observations on 5/25/2023 the resident was observed to be wearing the same hooded sweatshirt with an orange stain on the collar of the sweatshirt and gray cotton sweatpants as on 5/24/2023. During a surveyor interview on 5/25/2023 at approximately 11:00 AM with Certified Medication	S 590	The Service plan for resident #7 has been updated to reflect refusal of care and approaches to use with resident added to service plan. Staff has been educated on approaches to use with demented residents regarding care. Staff has been educated on reporting refusals timely to the nurse for intervention. DOW or designee will audit 20% of MC residents charts for refusal of care weekly every four weeks and monthly for six months. Any concerns identified staff will be in-serviced on appropriate interventions and service plans to be updated. Audits will be reviewed in Quarterly QA meetings every three months for compliance.	

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S 590	Continued From page 19 Technician, Staff C, she acknowledged the resident was wearing the same clothing as the day before. During a surveyor interview on 5/25/2023 at approximately 12:55 PM with the Regional Nurse, she was unable to provide evidence that Resident ID #7 received moderate personal assistance with dressing per his/her service plan.	S 590		