RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01515	A. BUILDING: _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALCYON AT WEST BAY LLC	2783 WEST SHORE ROAD WARWICK, RI 02889

(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 was conducted at this residence. Deficiencies were identified.	S 003		
S 285	Residency Requirements 2.4.14.A Residency Requirements 2.4.14 (A) Residency Requirements A. Each licensee, or his/her designee, through the assessment and evaluation procedures delineated in these regulations (see § 2.4.16(C) of this Part) shall be responsible to ensure that admission to and residency in an assisted living residence be limited to those individuals who meet the definition of "resident" in accordance with § 2.3(A)(32) of this Part. This Requirement is not met as evidenced by: Based on record review, surveyor observation, and staff interview, it has been determined that the residence retained a resident that does not meet the definition of a "resident" for 1 of 8 sample residents reviewed, ID #1. Finding are as follows: Per the Rules and Regulations for Licensing Assisted Living Residences the definition of a "resident" states in part "...persons who are bedbound or in need of the assistance of more than one (1) person for ambulation are not appropriate to reside in assisted living residences..." Per 2.4.1 (A)(4) of the regulation states "Any assisted living residence which offers to provide or provides services for residents receiving hospice services that are bed-bound or in need of	S 285	1. Assessments for residents in question were reviewed and determinations made for safe discharge per family and resident request. 2. All resident assessments reviewed for accuracy to ensure that residents are appropriate for residency per RI Assisted Living regulations. 3. Assessment nurse was educated by Director of Nursing on assisted living regulations and the mobility/functionality requirements for assisted living. 4. Ongoing procedure to maintain compliance is a monthly "At Risk" meeting in which all residents with mobility concerns are discussed in an interdisciplinary means. If residents are considered to need a higher level of care, a family meeting will be held and the discharge will be planned and executed per the RI Assisted Living regulations. 5. Date of Compliance 11/1/2023.	

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

Executive Director — 10/13/23

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S 285	Continued From page 1 assistance from more than one staff person for ambulation is required to be licensed at the F1 level, as defined in § 2.4.2(A)(1)(a) of this Part, and must have a license endorsement, issued pursuant to these regulations, to provide limited health services..." Record review reveals this residence is licensed as a F1 facility. The residence does not have a license endorsement to provide limited health services, which is required for any assisted living residence which offers to provide or provides residents that are bed-bound or in need of assistance from more than one person for ambulation with hospice services. Record review revealed the resident moved into the residence in April of 2022 with diagnoses including dementia and chronic venous hypertension. Additional record review revealed s/he was admitted to hospice services on 7/8/2023. Record review of Resident ID #1's comprehensive assessment dated 7/8/2023 states in part, "...COC (change in condition)...Physical Limitations: 8/31/23-Increasing difficulty with ADLs (activity of daily living) and ambulation...[resident] now needs a W/C (wheelchair) escort as short distance walks have now become more difficult...More frequently [resident] is in need of a two person assist with transfers...Transferring: 8/31/2023-recently has needed the assistance of 2 staff members due to decrease physical strength..." During a surveyor observation on 9/20/2023 at approximately 11:40 AM-11:50 AM, the resident was observed on the unit in a wheelchair. The resident was observed being propelled in the	S 285		

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S 285	Continued From page 2 wheelchair to the dining room by staff due to him/her being unable to ambulate. Additional record review of the resident's "Progress Notes" revealed s/he does not meet the definition of a resident as evidenced by: - 9/11/2023: "...Assisted to BR (bathroom) and back to bed 1-2 transfer/ambulation..." - 9/10/2023: "...[resident] has been 3-4 assist, his/her legs starts shaking...2nd shift reporting 2-3 assist [resident] has been requiring increased assistance from bed to chair...uses wheelchair..." - 9/9/2023: "...1st shift [resident] has been a 3 assist with transfer...uses wheelchair...2nd shift has been 2 assists from transfer..." - 8/31/2023: "Functional status assessed due to reports of resident needing assist of two...seems that his/her progressing dementia is causing him/her to loose the ability to walk...[resident] is unable to lift [his/her] legs..." - 8/26/2023: "...[resident] was 2 assist to transfer from chair to chair..." During an interview on 9/21/2023 at approximately 10:50 AM, the Executive Director and the Director of Wellness acknowledged the resident was not appropriate for continued residence due to the required assistance of two staff for transfer and ambulation.	S 285		
S 365	Residency Requirements 2.4.16.D Resident Assessment/Service Plans 2.4.16 (d) Resident Assessments and Service	S 365		

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S 365	Continued From page 3 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. 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 2 of 8 sample residents, ID #s 2 and 6. Findings are as follows: 1. Record review revealed Resident ID #2 moved into the residence in April of 2021 with a diagnosis of urinary retention. Record review revealed the resident received outside services for physical therapy, occupational therapy, and skilled nursing with a start of care date of 7/19/2023 through 8/21/2023. Record review of the resident's comprehensive assessment dated 3/26/2023 failed to reveal evidence the assessment was updated to reflect that the resident received the above-mentioned outside services. 2. Record review revealed Resident ID #6 moved into the residence in June of 2022 with a diagnosis of Chronic Obstructive Pulmonary Disease. Record review revealed the resident received physical therapy with a start of care date of	S 365	1. Assessments for residents in question have been reviewed and been updated accordingly. 2. Will complete an audit of all residents to ensure assessments are completed within the appropriate timeframe. Audit will be completed by 10/27/23. 3. A tracking sheet has been implemented to ensure all annual and 90-day nurse reviews are completed within the correct timeframe. This is to be reviewed quarterly by the Director of Health and Wellness. The tracking sheet is attached to this POC and all assessments will meet the compliance standards by 11/30/23. 4. To meet ongoing compliance requirements, a new nursing assessment (App C) and service plan will be conducted annually and with any changes from the resident's baseline (i.e., a return from a hospital admission or short-term rehabilitation facility or a significant decline from their baseline). 5. Our first quarterly review will be completed on December 13, 2023 and will meet compliance guidelines set above.	

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S 365	Continued From page 4 6/30/2023 and skilled nursing with a start of care date of 6/28/2023. Additionally, the resident had a hospitalization from 5/12/2023 through 6/27/2023. Record review of the resident's comprehensive assessment dated 12/22/2022 failed to reveal evidence the assessment was updated to reflect that the resident received outside services. Additionally, the assessment did not have an indication of the resident's hospitalization. During a surveyor interview on 9/20/2023 at approximately 2:20 PM with the Director of Wellness, she could not provide evidence the assessments were updated for Resident ID #2 and 6, as required.	S 365	10/6/23 All assessments will be signed by the Executive Director and the assessing nurse. To ensure this takes place the following process has been put in place.	
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 have the service plan signed, approved, and dated by a registered nurse and/or the certified assisted living residence administrator for 6 of 8 sample residents reviewed, Resident ID #s 1, 2, 3, 4, 5, and 6. Findings are as follows:	S 385	1. The assessing nurse will complete the assessment and service plan and route it to the DHW, who will review it for completeness and accuracy. This includes, but is not limited to, the signature of the assessing nurse. 2. The DHW will pass it to the Executive Director for final review and to sign the documents. 3. The assessment nurse will obtain the resident's or responsible party's signature. 4. The assessment will be placed in the chart. 5. Each quarter a review of new assessments will be conducted to ensure process compliance by the DHW. Unsigned service plans were from prior administration. Current administration has and will continue to sign all assessments and service plans timely and within the RI Dept of Health guidelines.	

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S 385	Continued From page 5 1. Record review revealed Resident ID #1 moved into the residence in April of 2022 with a diagnosis of chronic venous hypertension. Record review revealed a service plan dated 7/8/2023. Record review failed to reveal evidence that the service plan was signed and approved by the Administrator as required. 2. Record review revealed Resident ID #2 moved into the residence in April of 2021 with a diagnosis of urinary retention. Record review revealed a service plan dated 4/26/2023. Record review failed to reveal evidence that the service plan was signed and approved by the Administrator as required. 3. Record review revealed Resident ID #3 moved into the residence in March of 2023 with a diagnosis of dementia. Record review revealed a service plan dated 9/11/2023. Record review failed to reveal evidence that the service plan was signed and approved by the Administrator as required. 4. Record review revealed Resident ID #4 moved into the residence in July of 2023 with a diagnosis of dementia. Record review revealed a service plan dated 7/10/2023. Record review failed to reveal evidence that the service plan was signed and approved by the Administrator as required. 5. Record review revealed Resident ID #5 moved into the residence in August of 2021 with a diagnosis of Alzheimer's disease.	S 385		

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S 385	Continued From page 6 Record review revealed a service plan dated 8/12/2022 and updated on 3/1/2023. Record review failed to reveal evidence that the service plan was signed and approved by the Administrator as required. 6. Record review revealed Resident ID #6 moved into the residence in June of 2022 with a diagnosis of Chronic Obstructive Pulmonary Disease. Record review revealed a service plan dated 6/29/2022 and updated on 3/1/2023. Record review failed to reveal evidence that the service plan was signed and approved by the Administrator as required. During an interview on 9/21/2023 at approximately 10:20 AM, the Administrator and Director of Wellness could not provide evidence the service plans for Resident ID #s 1, 2, 3, 4, 5, and 6 were signed, as required.	S 385		
S 390	Residency Requirements 2.4.16.G.3 Resident Assessment/Service Plan 2.4.16 (G)(3) Service Plans 3. The service plan shall be reviewed by both parties at intervals not to exceed twelve (12) months and each time a resident's condition changes significantly and all changes shall be acknowledged in writing 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 review the service plan each time a resident's condition	S 390		

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S 390	Continued From page 7 changes significantly and failed to accurately reflect that the resident is receiving outside services for 2 of 8 sample residents reviewed, Resident ID #s 2 and 6. Findings are as follows: 1. Record review revealed Resident ID #2 moved into the residence in April of 2021 with a diagnosis of urinary retention. Record review revealed the resident received outside services for physical therapy, occupational therapy, and skilled nursing with a start of care date of 7/19/2023 through 8/21/2023. Record review of the resident's service plan dated 4/26/2023 failed to reveal evidence that the service plan was updated to reflect that the resident received the above-mentioned outside services. 2. Record review revealed Resident ID #6 moved into the residence in June of 2022 with a diagnosis of Chronic Obstructive Pulmonary Disease. Record review revealed the resident received physical therapy with a start of care date of 6/30/2023 and skilled nursing with a start of care date of 6/28/2023. Additionally, the resident had a hospitalization from 5/12/2023 through 6/27/2023. Record review of the resident's service plan dated 6/29/2023 failed to reveal evidence the service plan was updated to reflect that the resident received outside services. Additionally, the service plan did not have an indication of the resident's hospitalization.	S 390	1. Assessments for residents in question have been reviewed and been updated accordingly. 2. The assessment nurse will complete an audit of all residents to ensure assessments are completed and include all appropriate documentation from outside services. Audit will be completed by 10/27/23. 3. A bi-monthly tracking sheet will be provided by the outside agencies to the DHW which will be used to ensure all outside services are documented on resident assessments and service plans. This is to be reviewed quarterly by the Director of Health and Wellness. The tracking sheet is attached to this POC and all assessments will meet the compliance standards by 11/30/23. 4. To meet ongoing compliance requirements, all outside services that a resident is receiving will be clearly documented on the assessment and service plan. This will include the SOC, what the service is and the discharge dates of service. 5. Our first quarterly review will be completed on December 13, 2023 and will meet compliance guidelines set above.	

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S 390	Continued From page 8 During a surveyor interview on 9/20/2023 at approximately 2:20 PM with the Director of Wellness, she could not provide evidence the service plans were updated for Resident ID #2 and 6, as required.	S 390		