RI Deoartment of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01426	A. BUILDING: _____ B. WING	C 02/20/2025

Received
MAR 12 2025
Facilities Regulation

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PHYLLIS SIPERSTEIN TAMARISK ALR	3 SHALOM DRIVE WARWICK, RI 02886

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S 003	Initial Comments An unannounced complaint/incident investigation survey, ACTS reference numbers 99564, 99561, and 99563, was conducted at this residence on 02/20/2025 to determine compliance with state regulations. Deficiencies were identified.	S 003	S230 We have had multiple communications with PACE to resolve the medication management issues with them and Greenline pharmacy to ensure when there are medication changes, the orders are clear and the medication received from the pharmacy is packaged correctly. Please see attachment #1 attached recap of the communication.	3/12/2025
S 230	Organization And Management 2.4.13.A Management Of Services 2.4.13 (A/8) 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 the residence failed to provide care and services in accordance with the prevailing community standard of care relative to administering medications in accordance with written physician's orders for three of three sample residents, Resident ID #s 1, 2, and 3. Findings are as follows: According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states in part, "...The	S230	Resident ID #1 The resident returned from a SNF with the documentation and the SNF's reconciled med orders. On those orders there was no Lasix listed. Tamarisk did not receive (and has not in the past) a reconciled medication list from PACE post SNF return. Greenline pharmacy also did not receive this reconciled medication list as they had not delivered the medication to Tamarisk. Tamarisk then received an order on 1/31/2025 for an additional 20mg of Lasix to be administered. Upon receipt of this order, Tamarisk RN informed PACE that residents most recent medication orders (from SNF) did not include a daily 40mg dose of Lasix. Once this information was translated to PACE, their provider sent the order for the Lasix. As Tamarisk did not have the medication available for this resident, we alerted Greenline pharmacy that we were unable to administer until delivered. (Please see attachment #2 medication list at time of d/c from SNF). We started the administration of the medication once received from the pharmacy	

3/13/25

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Heleyne G Ramirez — TITLE: Executive Director — (X6) DATE: 3/12/25

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S230	Continued From page 1 physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients..." Record review of a community reported complaint sent to the Rhode Island Department of Health on 2/13/2025 from a medical provider, alleged Resident ID #1 had missed one week of a diuretic medication. The report further alleged Resident ID #s 2 and 3 had been given incorrect doses of Vitamin D3. 1.Record review of Resident ID #1 revealed s/he was admitted to the residence in April of 2024 with diagnoses including, but not limited to, atherosclerotic heart disease and dementia. Record review of a progress note dated 1/31/2025 revealed the resident was to have been receiving 40 milligrams (mg) of Lasix (medication used to treat edema) daily with a start date of 1/13/2025 and that an additional dose of 20 mg of Lasix for a total of 60 mg for 5 days was to be implemented on 1/31/2025. Record review failed to reveal that Lasix 40 mg was listed on the physician's orders with a start date of January 13, 2025. Additionally, the 20 mg of Lasix for a total of 60 mg of Lasix was also not listed. The record failed to reveal Resident ID #1 received Lasik medication as ordered from 1/13/25-2/6/2025. 2) Record review of Resident ID #2 revealed s/he was admitted to the residence in February of 2024 with a diagnosis that includes, but is not limited to, gait and mobility abnormalities. ...	S 230	Continued from Page 1 Resident ID #2 and #3 The daily vitamin D order was not sent with an accompanying d/c order for the weekly vitamin D. Due to this, it was added to the medication regime and upon medication review by the Tamarisk RN, the duplication of vitamin D administration was brought to PACE's attention. PACE had not sent the d/c order of the weekly vitamin D to Greenline pharmacy either as they continued to deliver both the daily and weekly dose. Upon discovery, PACE sent a reconciled medication list showing their start date of daily vitamin D in lieu of weekly vitamin D. Moving forward PACE has agreed that whenever there is a medication change, they will forward a complete and updated medication list to the Tamarisk 9not previously done). Whenever there is a discontinuation of a medication Tamarisk will receive an updated medication list along with the d/c order and, more importantly, if a new medication order is replacing or changing an existing medication order this will be noted clearly on the same order. As Greenline delivers multi-dose blister packs every 28 days, Tamarisk proposed to PACE during meeting held on 3/4/25 that they send us the medication list for each PACE participant 3-4 days prior to the monthly medication delivery as an additional quality assurance check. PACE did not feel that this was necessary. As a secondary solution, Tamarisk requested that PACE send a monthly medication list prior to the 28-day supply delivery for the next three months to ensure that the new processes developed during the meeting held on 3/5/2025 are effective.	

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s 230	Continued From page 2 Record review of the physician's orders revealed Vitamin D3 50,000 units weekly and Vitamin D3 2,000 units daily were not discontinued per primary care physician orders in November as evidenced by the Medication Administration Record for November 2024 through January 2025 which revealed the resident was receiving 50,000 units of Vitamin D3 weekly 2,000 units of Vitamin D3 daily. Additionally, record review failed to reveal the new physician's order for 1,000 units of Vitamin D3 daily was followed. 3. Record review of Resident ID #3 revealed s/he was admitted to the residence in April of 2024 with a diagnosis that includes, but is not limited to, dysphagia (difficulty swallowing). Record review of the physician's orders revealed Vitamin D3 50,000 units one time weekly and 2,000 units of Vitamin D3 daily were not discontinued per primary physician orders in January as evidenced by the Medication Administration Record for June 2024 through January 2025 which revealed the resident was receiving 50,000 units of Vitamin D3 weekly and 2,000 units of Vitamin D3 daily. Additionally, record review failed to reveal the new physician's order for 1,000 units of Vitamin D3 was followed. During a surveyor interview on 2/20/2025 at 2:15 PM with the Director of Wellness, she acknowledged that the three residents did not receive their medications per the physician orders.	S230	Continued from page 2 As this request has not been acknowledged, on 2/27/25, Tamarisk requested the most up to date orders that PACE had for each of the eleven participants that reside at Tamarisk. After receiving the first complete medication lists, Tamarisk was informed via voicemail to disregard these lists as they were inaccurate. Tamarisk reached out to PACE and was told that they were performing an internal audit, and the documentation would be delayed. With the PACE audited information, Tamarisk now has a complete and accurate medication list for each participant that resides in the community. Nursing has started a binder and electronic folder of these orders. With the new agreed upon process, PACE will send a complete reconciled medication list with every medication change; the newest list received will be compared to the old list and if accurate, the new list will supersede the old list. This documentation will then be used to check in the medications supplied by Greenline every 28 days. Any discrepancies found will be brought to our point person at PACE immediately. The process will be reviewed monthly and presented at quarterly QA meetings which is also attended by a NP from PACE. This stop gap is not necessary for the non PACE residents as we use the pharmacy connect system through our EMR.	

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S 380	Continued From page 3	S 380		
S 380	Residency Requirements 2.4.16.G.1 Resident Assessment/Service Plan 2.4.16 (G) (1) Service Plans 1. Within a reasonable time after move-in, not to exceed seven (7) days, the Administrator shall be responsible for the development of a written service plan based on the initial assessment. The service plan shall include at least: a. The services and interventions needed, including all services provided by outside healthcare agencies (e.g., home nursing care, hospice); b. Description, frequency, duration relating to the service or intervention, including personal assistance, medication, special diets, recreational activities, and other similar services rendered; c. Party responsible for arranging and/or providing the service; and d. The resident's requested and/or therapeutically needed recreational and social activities. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined the residence failed to ensure the service plan was updated to reflect changes of condition and interventions needed for one of three sample residents, Resident ID #1. Findings are as follows:	S 380	S380 On 1/23/25, it was noted that the resident had a scrape on [redacted]shin. An adhesive bandage was applied. PACE was notified and the resident was seen at PACE on 1/24/2025 with no new orders pertaining to the now healed scrape. No care plan changes were required. We have added a note that the resident uses Tubi Grips not Teds stockings (to the Care Plan) The services previously assigned to the resident correctly specified putting "Tubi Grips", not "Teds" on in the am and removing in the PM since the order was put into place. (See attachment 3). Going forward a note will be added to the care plan under "special dressing needs – compression stockings" to specify Tubi Grips if ordered as TEDS is the auto generated option. Going forward we will document any minor skin issue we have been made aware of in the service plan immediately. Service plans will be audited quarterly of any new minor skin issues that we have been made aware of and treated in any way.	3/12/2025

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S 380	Continued From page 4 Record review of Resident ID #1 revealed a service plan dated 1/17/2025 which was not revised on 1/24/2025 to reflect the resident's new skin condition that required a dressing on his/her lower leg. Additional review of the service plan revealed that it was not revised on 1/31/2025 to reflect the resident's need to wear Tubi-grips (bandages used to reduce swelling) to his/her lower legs two times daily. During an interview on 2/21/2025 at approximately 2:30 PM with the Director of Wellness, she acknowledged that the service plan for Resident ID #1 was not updated to reflect the resident's current skin condition that required a cream application and Tubi-grips.	S 380		