RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01496	A. BUILDING: _____ B. WING _____	C 06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS ON THE EAST SIDE	101 HIGHLAND AVENUE PROVIDENCE, RI 02906

RECEIVED JUN 29 FACILITIES REGULATION

(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 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 the residence failed to provide care and services in accordance with prevailing community standards of care relative to skin assessment for "at risk" residents and following assessment protocol for two of two residents reviewed for wound care, ID #s 1 and 2 and following physician's orders for one of three sample residents, ID #3. Findings are as follows: According to AHCPR (Agency for HealthCare Policy and Research) Clinical Practice Guideline, Pressure Ulcers in Adults: Prediction & Prevention Number 3, May, 1992, the skin of the "at risk" patient should be inspected on admission and at least daily.	S 230	Tag: S230 Weekly Skilled notes and wound measurements have been provided by skilled agency and put in Resident #1 & #2 chart. In-service will be completed by 7/7 with all Nurses on collaboration with Home Care Agency nurses and need for ALR to view and document in chart of residents receiving skilled wound care on a weekly basis. Additionally, nurses will be trained to document obtaining lab specimens or inability to obtain and notification of physician of same. RCD/RN's will do weekly rounds with Skilled Nursing Agency to view dressing changes and documentation on going. All CMT's will be in serviced by 7/7 on communication with RCD/nurse regarding obtaining lab specimen or inability to obtain lab specimen. In-service will include methods to obtain specimens. Communication to nurse will be same day.	7/7/23

7/7/23

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Van Gorden — TITLE — (X6) DATE: 6/29/23

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S 230	Continued From page 1 According to Clinical Nursing Skills, 5th Edition, 2000, assessment requires skilled observation, reasoning, and a theoretical knowledge base to gather and differentiate, verify, organize data, and document the findings. Assessment is a critical phase because all the other steps in the process depend on the accuracy and reliability of the assessment. According to The Guideline for Prevention and Management of Pressure Ulcers 2003 edition, pressure ulcers are to be assessed and monitored at each dressing change, reassessed and measured at least weekly, including description of location, tissue type, size tunneling, exudates (amount, type, character, and odor), presence/absence of infection, wound edges, stage, periwound skin, pain, and adherence to prevention and treatment. According to the Alzheimer's Association, "Alzheimer's disease (dementia) is a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain." According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, "The 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." According to the National Library of Medicine, "urinary tract infection (UTI) is a bacterial infection of the bladder and associated structures ...diagnosis is a combination of signs, symptoms,	S 230		

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S 230	Continued From page 2 and urinalysis." 1) Record review revealed ID #1 was admitted to the residence in March of 2022 with diagnoses including, but not limited to: Alzheimer's disease and congestive heart failure. Record review of ID #1's outside provider notes revealed he/she received skilled nursing (SN) services from 10/9/2022-3/27/2023 for wound care on legs/buttocks and was re-admitted for services on 4/4/2023 for "scattered superficial open areas." Record review of a residence's nursing note dated 6/16/2023 revealed, "[Agency Registered Nurse] requested resident to be sent to [hospital] for wound care eval (evaluation), she has been completely (sic) daily wound care with no improvement..." Record review of skilled nursing notes dated 10/9/2022-3/27/2023, and 4/4/2023-6/15/2023 provided to the residence by the outside agency failed to reveal staging of the wound and weekly wound measurements. Additionally, the record failed to reveal any skin assessments performed by the residence. Resident ID #1 was admitted to a short-term rehabilitation facility for wound care at the time of this survey. 2) Record review revealed ID #2 was admitted to the residence in May of 2019 with diagnoses including, but not limited to: Alzheimer's disease and chronic obstructive pulmonary disease. Observation of Resident ID #2 on 6/21/2023 at	S 230		

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S 230	Continued From page 3 approximately 3:00 PM revealed right lower leg edema and redness with a wound dressing. Record review of ID #2's outside provider notes revealed he/she receives SN services for wound care to his/her right shin with a start of care date of 5/17/2023. Record review of skilled nursing notes dated 5/17/2023-6/19/2023 provided to the residence by the outside agency failed to reveal staging of the wound and weekly wound measurements. Additionally, the record failed to reveal any skin assessments performed by the residence. During an interview on 6/22/2023 at approximately 3:00 PM, the Resident Care Director (RCD) was unable to provide evidence the residence assessed ID #2 and 3's wounds and documentation from the outside skilled nursing agency with all required wound assessment information. 3) Record review revealed ID #3 was admitted to the residence in January of 2023 with diagnoses including, but not limited to: Alzheimer's disease and hypothyroidism. Record review of physician note dated 1/20/2023 reveals, "Patient inactive medical problems, UTI's (urinary tract infections)." Record review of a nursing note dated 5/25/2023 revealed, "Took a verbal order from [Provider] to have a urine done on [ID #3], Change of mental status, family requested due to frequent UTI's." The record failed to reveal evidence the urine was collected for analysis. Additionally, the record	S 230		

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S 230	Continued From page 4 failed to reveal the ordering physician was notified of the difficulty obtaining the urine. Record review of provider order note dated 6/6/2023, 11 days later, reveals a diagnosis of UTI. During a surveyor interview on 6/22/2023 the RCD revealed ID #3 is incontinent of urine and bowel which led to difficulty getting a clean urine sample for UTI testing. The RCD was unable to provide evidence of notification to the physician that the residence was unable to obtain the urine for analysis.	S 230		
S 310	Residency Requirements 2.4.15.A Resident Records 2.4.15 (A) Resident Records A. Each residence shall, at a minimum, maintain the following information for each resident: 1. The resident's name; 2. The resident's last address; 3. The name of the person or agency referring the resident to the home; 4. The name, specialty (if any), telephone number, and emergency telephone number of each physician who is currently treating the resident; 5. The date the resident began residing in the home; 6. A list of medications taken by the resident,	S 310	Tag S310 RCD/RN's will conduct weekly rounds and document according with Skilled Nursing Agency to view dressing changes ongoing. Outside Agency Skilled Nursing Weekly notes of wound care and assessment will be obtained and placed in charts ongoing.	7/7/23

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S 310	Continued From page 5 including dosage, and specific records of medication administration as required by the Department; a. In residences licensed at the M2 level, if a resident refuses to provide the information cited in § 2.4.15(A)(6) of this Part, this fact shall be documented in the resident's service agreement. 7. Written acknowledgments that the resident has signed and received copies of the rights as provided in R.I. Gen. Laws § 23-17.4-16; 8. Information about any specific health problems of the resident, which may be useful in a medical emergency, including diagnostic and/or therapeutic orders; 9. A record of personal property and funds which the resident has entrusted to the residence; 10. The name, address, and telephone number of a person identified by the resident who should be contacted in the event of an emergency or death of the resident and the name, address, and telephone number of the legal guardian; 11. Any other health-related emergency, or pertinent information which the resident requests the residence to keep on record; 12. A copy of the initial and periodic assessments described in § 2.4.16 of this Part; 13. A copy of the service plan and nurse review as described in § 2.4.16 of this Part;	S 310		

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S 310	Continued From page 6 14. A copy of the residency agreement as described in § 2.4.14(C) of this Part. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to maintain, at a minimum, information about any specific health problems of the resident, which may be useful in a medical emergency, including therapeutic orders for 2 of 3 sample residents reviewed that are receiving outside services, Resident ID #s 1 and 2. Findings are as follows: 1) Record review revealed ID #1 was admitted to the residence in March of 2022 with diagnoses including, but not limited to: Alzheimer's disease and congestive heart failure. Record review of ID #1's outside provider notes revealed he/she received skilled nursing (SN) services from 10/9/2022-3/27/2023 for wound care on legs/buttocks and was re-admitted for services on 4/4/2023 for "scattered superficial open areas." Record review of a residence's nursing note dated 6/16/2023 revealed, "[Agency Registered Nurse] requested resident to be sent to [hospital] for wound care eval (evaluation), she has been completely (sic) daily wound care with no improvement..." Record review of skilled nursing notes dated 10/9/2022-3/27/2023, and 4/4/2023-6/15/2023 provided to the residence by the outside agency failed to reveal staging of the wound and weekly	S 310		

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S 310	Continued From page 7 wound measurements to ensure the resident remained appropriate for residency. Resident ID #1 was admitted to a short-term rehabilitation facility for wound care at the time of this survey. 2) Record review revealed ID #2 was admitted to the residence in May of 2019 with diagnoses including, but not limited to: Alzheimer's disease and chronic obstructive pulmonary disease. Observation of Resident ID #2 on 6/21/2023 at approximately 3:00 PM revealed right lower leg edema and redness with a wound dressing. Record review of ID #2's outside provider notes revealed he/she receives SN services for wound care to his/her right shin with a start of care date of 5/17/2023. Record review of skilled nursing notes dated 5/17/2023-6/19/2023 provided to the residence by the outside agency failed to reveal staging of the wound and weekly wound measurements to ensure the resident remained appropriate for residency. During an interview on 6/22/2023 at approximately 3:00 PM, the Resident Care Director (RCD) was unable to provide evidence ID #2 and 3's wound documentation from the outside skilled nursing agency contained all required wound assessment information.	S 310		