RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01509	A. BUILDING: _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STILLWATER ASSISTED LIVING AND SKILLED	20 AUSTIN AVENUE GREENVILLE, RI 02828

(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. A deficiency was identified.	S 003	RECEIVED MAR 03 2023 FACILITIES REGULATION	
S 360 DTP 3/10/23	Residency Requirements 2.4.16(C) Resident Assessment/Service Plans 2.4.16 (C) Resident Assessments and Service Plans C. The Department-approved assessment form, or such other assessment form as approved by the Department, shall be utilized in completing the assessment on each resident who is admitted to the residence. (Approved Department form is available for downloading online at http://health.ri.gov/forms/assessment/AssistedLivingResident.pdf). 1. Assisted living residences not intending to use the Department's assessment form shall submit their proposed assessment forms with a cover letter of intent to the Center for Health Facilities Regulation as specified in § 2.4.6(A) of this Part. 2. All assessment forms shall report information appropriate to determine compatibility and compliance with the residency criteria, and shall indicate that the resident's needs can be met by the assisted living residence within its licensure level, and shall gather information appropriate for the development of an individualized service plan. a. The assessment form shall be designed to demonstrate compliance with the assisted living residence's criteria for residency. b. The assessment form shall also be designed	S 360	The filing of this Plan of Correction (POC) does not constitute that the deficiencies alleged did in fact exist, rather this POC is filed as evidence of the facility's continuing commitment to high quality resident care in full compliance with state and federal regulations. Completion date for optimal compliance with POC will be February 28, 2023.	

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE
Robert Conroy — Administrator — 2/19/23

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01509	A. BUILDING: _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STILLWATER ASSISTED LIVING AND SKILLED	20 AUSTIN AVENUE GREENVILLE, RI 02828

(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 360	Continued From page 1 to demonstrate that the assisted living residence can meet the resident's needs and preferences. 3. The assessment form shall also be designed to provide information appropriate for the development of an individualized service plan in accordance with § 2.4.16(G)(1) of this Part. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined the resident's comprehensive assessment form failed to report the resident's needs and gather information appropriate for the development of an individualized service plan for one of three sample residents reviewed, ID # 1. Findings are as follows: Review of a facility reported incident submitted to the Rhode Island Department of Health on 1/27/2023 by the Wellness Director revealed that on 1/27/2023 the facility received a call from a nearby attorney's office stating that Resident ID #1 was sitting in the office and the facility would need to pick him/her up. Record review revealed Resident ID # 1 was admitted to the residence in January 2021 with diagnoses including, but not limited to bipolar disorder hypertension, and coronary artery disease. Record review of the resident's comprehensive assessment dated 10/7/2021 revealed the section related to " Behavioral Information" was not completed, this section specifically relates to wandering behavior. Further review of the comprehensive assessment also revealed that the assessment had never	S 360	a) Residents ID#1 did not experience any adverse outcome. The Wellness Director has since reviewed and revised the comprehensive assessment accordingly. A proper plan is in place based on the resident's assessed status. b) We recognize the potential risk to residents if the comprehensive assessments are not thoroughly and/or accurately completed. The Wellness Director has since reviewed all residents' comprehensive assessments to ensure accuracy of information and thoroughness of completion of all sections of the assessment tool, to include the Administrator's signature. c) The Wellness Director is re-educating those nurses who are responsible to complete these assessments of the importance of assuring timely, accurate and thorough completion of assessments to include the proper service plan based on the assessed areas of risk/concern. The Administrator will ensure his signature is evident on said assessments. The Wellness Director and Administrator will meet routinely and conduct random audits of charts to ensure compliance with these requirements.	

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01509	A. BUILDING: _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STILLWATER ASSISTED LIVING AND SKILLED	20 AUSTIN AVENUE GREENVILLE, RI 02828

(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 360	Continued From page 2 been signed as approved by the Administrator. During a surveyor interview with the Administrator and Director of Wellness on 1/31/2023 at 1:00 PM both acknowledged that the resident's comprehensive assessment was not complete and failed to provide information regarding the resident's wandering assessment. The Administrator further acknowledged that he had not signed the admission comprehensive assessment, as required.	S 360	d) The Administrator is responsible to ensure this POC is executed timely and effectively. We will conduct random audits (accuracy and completion of assessments and service plans) and formally monitor this for the next three months after which time, the QAPI Committee will evaluate our level of compliance and determine if we will "drop" the indicator or continue.	