PRINTED: 09/01/2023
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RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01495	A. BUILDING: _____ B. WING _____	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING	55 TOLL GATE FARM ROAD WARWICK, RI 02886

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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 all care and services to all residents in accordance with the prevailing community standard of care, relative to accurate documentation for medication administration for 1 of 3 residents reviewed, Resident ID #1. Findings are as follows: According to the ANA's (American Nursing Association) Principles for Nursing Documentation, 2010, which states in part "...high quality documentation is: accessible, accurate, relevant, and consistent..." According to Basic Nursing, Mosby, Third edition,	S 230	RECEIVED SEP 18 2023 FACILITIES REGULATION Employee (A) has completed the following Inservice trainings due to med error. These training sessions were. **Managing Medication in ALF's: Knowing the Side Effects 8/25/23** **Medication Management of ALF's: Assisted with Self Administration. 8/25/23** **Assisting with Self Administration of Medications: The Basic 8/26/23** 9/19/23	

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

Executive Director 9/15/23

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S 230	Continued From page 1 states in part, "...after administrating a drug the nurse records it immediately on the appropriate record form. Recording of the drug includes the name of the drug, dosage, route, and exact time of administration..." Record review revealed that ID #1 was admitted to the residence in September of 2018 with diagnoses that include, but are not limited to, Alzheimer's disease, epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), and syncope (loss of consciousness). Record review of the physician's orders dated 5/17/2022 reveal an order for Potassium Chloride ER (extended release): - 10 MEQ (milliequivalent) tab by mouth twice per day and a 20 MEQ tab by mouth twice a day (8:00 AM and 8:00 PM) to equal 30 MEQ twice daily for hypokalemia (a blood level that is below normal in potassium that can result in fatigue, confusion, muscle cramps, and abnormal heart rhythms). Record review of the Medication Administration Record (MAR) for August 2023 revealed the following missed potassium chloride ER 20 MEQ doses: -8/19/2023 at 8:00 PM -8/20/2023 at 8:00 AM -8/21/2023 at 8:00 AM and 8:00 PM -8/22/2023 at 8:00 AM and 8:00 PM -8/23/2023 at 8:00 AM -8/24/2023 at 8:00 AM and 8:00 PM Further review of the MAR revealed potassium chloride ER 20 MEQ was signed off as given at	S 230	An Inservice for all Med Techs has been completed. High lights of this training were what to do when the family is suppling the community with medication for their loved ones. Family members are to be contacted immediately when the resident's medication is running low. If the family is unable to supply the proper dosage of medication. The community would reach out to our preferred pharmacy to purchase the medication, and let the family know that they will be billed for any medication that may be needed. Next Page	9/6

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S 230	Continued From page 2 8:00 PM on 8/20/2023 and on 8/23/2023 when the medication was not available per documentation of prior administration times. During a surveyor interview with Certified Medication Technician, Staff A, on 8/30/2023 at 9:55 AM, she revealed that on 8/24/2023 when administering the resident's medication, she realized the resident was out of the 20 MEQ of potassium chloride tablets. She further revealed she failed to notify anyone on her shift that the resident was out of this medication. During a surveyor interview with the Regional Director of Wellness on 8/30/2023 at 2:46 PM, she acknowledged that the above-mentioned medication was documented as given on 8/20/2023 and on 8/23/2023 at 8:00 PM, when it was not available. Additionally, she was unable to provide evidence that the medication record was accurate relative to the administration of potassium chloride tablets.	S 230	Employee a, and med techs will participate in med management retraining as there were multiple med techs involved in this med error. - all MedTech's will have a coach and counsel as part of the progressive disciplinary process that our company follows - all involved MedTech's have will have a competency training to ensure that they are accurately distributing medication.	10/31/23
S 565	Residential Care Services 2.4.24.B.1 Medication Services 2.4.24 (B) (1) Administration of Medications 1. Residences licensed at the M1 level may administer medications to residents including, but not limited to, removing medication containers from storage, assisting with the removal of a medication from a container for residents with disability which prevents independence in this act, and/or administering the medication directly to the resident. a. The resident or guardian must provide written authorization for the residence to provide	S 565		

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S 565	Continued From page 3 administration of medications. b. Medications shall be administered in accordance with written orders of a physician. The residence must provide in writing, a description of services provided by the residence to each physician, including limitations on service. c. All medications must be checked against a physician's orders by a licensed nurse, or pharmacist. d. The resident must be identified prior to administration of any medication. e. The medication must be in the original pharmacy-dispensed container with proper label and directions attached and be administered in accordance with such label. f. Injectable medications, including but not limited to insulin, which cannot be self-administered by the resident, must be administered by a licensed nurse. g. There shall be written a policy/procedure for the disposal of hypodermic needles, syringes and other such instruments that is in compliance with rules and regulations governing Hypodermic Needles, Syringes & Other Such Instruments (Part 20-15-6 of this Title). (1) The legal destruction of hypodermic needles, syringes or other such instruments is the responsibility of the last entitled or authorized possessor. (AA) All personnel or residents legally authorized to use disposal syringes and needles,	S 565		

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S 565	Continued From page 4 shall destroy them after one (1) use. (BB) Excess and undesired needles, syringes and other such instruments shall be stored in impervious, rigid, puncture- resistant container for disposal. Intact needles shall be placed directly into the collection containers. (CC) Personnel handling disposal waste materials such as needles, syringes, and other such instruments may treat and destroy such waste by a DEM-approved alternative treatment/destruction technology or prepare the regulated medical waste for off-site transport by a DEM-permitted medical waste transporter. h. Individual medication records must be retained for each resident to whom medications are being administered and each dose administered to the resident must be properly recorded. i. Any medication administered by the residence and refused by a resident shall be documented and reported, as appropriate. j. Medications shall be stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access. Provisions for safe storage may include lockable containers, secure spaces, or lockable units, as appropriate to the residence and the resident population. k. All medication in the residence, regardless of whether controlled by employees or by the resident, shall be stored securely as stated in § 2.4.24(A)(3)(a)(8) of this Part.	S 565		

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S 565	Continued From page 5 I. All centrally stored medications shall be maintained in accordance with manufacturer's labeling and administered by authorized personnel. 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 all medications were administered in accordance with written physician's orders for 1 of 3 residents reviewed, Resident ID #1. Findings are as follows: 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." Record review revealed that Resident ID #1 was admitted to the residence in September of 2018 with diagnoses that include, but are not limited to, Alzheimer's disease, epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), and syncope (loss of consciousness). Record review of the physician's orders dated 5/17/2022 reveals an order for Potassium Chloride ER (extended release): - 10 MEQ (milliequivalent) tab by mouth twice per day and a 20 MEQ tab by mouth twice a day (8:00 AM and 8:00 PM) to equal 30 MEQ twice daily for hypokalemia (a blood level that is below normal in potassium that can result in fatigue, confusion, muscle cramps, and abnormal heart rhythms).	S 565	All med tech documents/signs off that the medication was not administered per order due to it not being available: the med tech then notifies the RCD/nurse that the medication is not available, the RCD/nurse then calls to communicate the medication needed to the family as well as providing the notification to the Doctor to inform them that the medication was not available to administer and that family has been notified to alert the Primary Physician to the occurrence but also that a prescription may also be needed to be sent to the communities preferred pharmacy. The RCD/nurse should then document all the notifications and the response of the family and Dr in the residents' EHR.	6D 9/19/23

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S 565	Continued From page 6 Record review of the Medication Administration Record (MAR) for August 2023 revealed the following missed potassium chloride ER 20 MEQ doses: -8/19/2023 at 8:00 PM -8/20/2023 at 8:00 AM -8/21/2023 at 8:00 AM and 8:00 PM -8/22/2023 at 8:00 AM and 8:00 PM -8/23/2023 at 8:00 AM -8/24/2023 at 8:00 AM and 8:00 PM Further review of the MAR for August revealed that on 8/24/2023 the resident did not receive his/her potassium chloride ER 10 MEQ at 8:00 PM, as well as the 20 MEQ, to equal the 30 MEQ dose as ordered. Record review failed to reveal evidence that the physician was made aware of the above-mentioned medications not being administered to the resident, as ordered. Record review of a progress note dated 8/24/2023 reveals that the resident fell, striking his/her head, and was sent out to the emergency room for evaluation. Record review of the resident's continuity of care (COC) form from the ER dated 8/24/2023 revealed that the resident's potassium level was 2.2, critically low. He/she was given 60 MEQ of intravenous (administered into a vein) potassium over 6 hours at the emergency room. Low potassium levels can cause weakness, fatigue, confusion, and an abnormal heart rhythm. During a surveyor interview with Certified Medication Technician, Staff A, on 8/30/2023 at	S 565	When a family member is suppling the community with medication for their loved ones. (Our Residents) The Primary Physician will be notified that the proper dosage of the medication is not being supplied by the family..	

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S 565	Continued From page 7 9:55 AM, she revealed that on 8/24/2023 when administering the resident's medication, she realized the resident was out of the 20 MEQ of potassium chloride tablets. She further revealed she failed to notify anyone on her shift that the resident was out of this medication. During a surveyor interview with the Regional Director of Wellness on 8/30/2023 at 2:46 PM, she acknowledged that the above-mentioned medications were not documented as being administered on the dates and times mentioned above, and she could not provide evidence that the resident was given his/her medications as ordered by the physician.	S 565		