RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01383	A. BUILDING: _____ B. WING _____	C 05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS ASSISTED LIVING	47 BARKER AVENUE WARREN, RI 02885

(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 and a biennial State licensure survey (4BS311, 05/05/2023) were conducted at this residence.	S 003	RECEIVED JUN 01 2023 FACILITIES REGULATION	

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Director — (X6) DATE: 5/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 003	Initial Comments An unannounced biennial State Licensure survey and a complaint/incident investigation survey (1G0Z11, 05/05/2023) were conducted at this residence. Deficiencies were identified relative to the State Licensure survey.	S 003		
S 185	Organization And Management 2.4.12(G)(2) Administrative Management 2.4.12 (G) (2) Employee Training 2. The administrator shall ensure that all new employees who will have regular contact with residents and provide residents with personal care shall receive at least ten (10) hours of orientation and training within thirty (30) days of hire and prior to beginning work alone in the assisted living residence, in addition to the areas stipulated in § 2.4.12(G) of this Part. Such areas include: a. Basic sanitation; b. Food service; c. Basic knowledge of cultural differences; d. Basic knowledge of aging-related behaviors including dementia and Alzheimer's disease; e. Personal assistance; f. Assistance with medications; g. Safety of residents; h. Body Mechanics; i. Resident Transfers (required for residences licensed at the F1 level for fire safety); j. Record-keeping; k. Service plans; and l. Internal reporting. This Requirement is not met as evidenced by: Based on record review and staff interview it has	S 185		

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

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S 185	Continued From page 1 been determined the administrator failed to ensure all new employees received at least ten hours of orientation and training within thirty days of hire and prior to beginning work alone in the residence, in the areas stipulated in § 2.4.12(G) of the regulations for four of five sample employees, Staff A,B,C, and D. Findings are as follows: 2.4.12 G 1 Employee Training includes: a. Fire prevention; b. Recognition and reporting of abuse, neglect, and mistreatment; c. Assisted living philosophy (goals/values: dignity, independence, autonomy, choice); d. Resident's rights; e. Confidentiality. f. Emergency preparedness and procedures; g. Medical emergency procedures; h. Infection control policies and procedures; and i. Resident elopement. 2.4.G 2 Employee Training includes: a. Basic sanitation; b. Food service; c. Basic knowledge of cultural differences; d. Basic knowledge of aging-related behaviors including dementia and Alzheimer's disease; e. Personal assistance; f. Assistance with medications; g. Safety of residents; h. Body Mechanics; i. Resident Transfers (required for residences licensed at the F1 level for fire safety); j. Record-keeping; k. Service plans; and	S 185	**S 185 In-Service Training New Staff** **5/30/2023** • The corrective action will be all new staff members will have Initial training upon hiring and ongoing training and not to exceed the twelve months. • The corrective action which will be accomplished. of those staff members found to have been affected by the deficient practice, will be to immediately add the following topics to be added to all staff members' in-service training calendar • Fire Prevention • Recognizing and reporting Abuse, Neglect and Mistreatment • Residents Rights • Confidentiality • Assisted Living Philosophy/Dignity • Emergency Preparedness and Procedures • Resident Elopement • Medication Assistance • Basic Sanitation • Food Services • Basic Knowledge of aging-related behaviors including Alzheimer's and Dementia • Basic knowledge of cultural differences • Personal Assistance • Assistance with Medications • Safety of Residents • Body Mechanics • Record Keeping • Service Plans • Internal Reporting • Several of these topics were included in our Residents Rights training module. • Director of Nursing Services personnel record will be updated on-going with a copy of all on-going in-services that are kept in her personnel record at Grace Barker Health. • The corrective action will be monitor to ensure the deficient practice will not reoccur through periodic audit review of personnel charts and updating annually all in-services that are required. • The corrective action will be to monitor to ensure the deficient practice will not recur through periodic audits on random staff charts and through inclusion in our QA/QI at each quarterly meeting.	

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S 185	Continued From page 2 I. Internal reporting. Record review of the following staff revealed they did not receive initial training in the following areas: - Assisted living philosophy (goals/values: dignity, independence, autonomy, choice) - Emergency preparedness and procedures - Medical emergency procedures - Resident elopement - Basic knowledge of aging-related behaviors including dementia and Alzheimer's disease - Personal assistance 1) Staff A was hired as the Director of Nursing in November of 2022 2) Staff B was hired in March of 2022 as a Certified Nurses Aide (CNA)/Certified Medication Technician (CMT) 3) Staff C was hired in January of 2022 as a CNA/CMT 4) Staff D was hired in October of 2021 as a CNA/CMT During an interview on 05/05/2023 at approximately 1:00 PM, the Executive Director was unable to produce evidence the above employees received initial training in the above stated areas.	S 185		
S 190	Organization And Management 2.4.12(H) Administrative Management 2.4.12 (H) In-service Training	S 190		

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S 190	Continued From page 3 1. Employees shall have on-going, at intervals not to exceed twelve (12) months, in-service training as appropriate for their job classifications and including the topics cited in § 2.4.12(G) of this Part. 2. All new employee orientation and on-going in-service training shall be documented in the employee's personnel file, and maintained onsite at the licensed residence. 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 that employees shall have on-going, at intervals not to exceed twelve (12) months, in-service training as appropriate for their job classifications and including the topics cited in § 2.4.12(G) of the regulations for two of two sample employees hired before 2022, Staff D and E. Findings are as follows: 1) Record review revealed Staff D, Certified Nursing Assistant (CNA)/ Certified Medication Technician (CMT), had a hire date of 10/15/2021. Personnel record review failed to reveal evidence Staff D received the following on-going in-service trainings in 2022: fire prevention, recognition and reporting of abuse, neglect, and mistreatment, assisted living philosophy, resident's rights, confidentiality, emergency preparedness and procedures, resident elopement, basic sanitation, basic knowledge of cultural differences, personal assistance, medication assistance, safety of residents, body mechanics, record-keeping, service plans, and internal reporting.	S 190	**S 190 In-Service Training** **5/30/2023** • The corrective action will be all staff members will have ongoing training and not to exceed the twelve months. • The corrective action which will be accomplished. of those staff members found to have been affected by the deficient practice, will be to immediately add the following topics to be added to all staff members' in-service training calendar • Fire Prevention • Recognizing and reporting Abuse, Neglect and Mistreatment • Residents Rights • Confidentiality • Assisted Living Philosophy/Dignity • Emergency Preparedness and Procedures • Resident Elopement • Medication Assistance • Basic Sanitation • Food Services • Basic Knowledge of aging-related behaviors including Alzheimer's and Dementia Basic knowledge of cultural differences • Personal Assistance • Assistance with Medications • Safety of Residents • Body Mechanics • Record Keeping • Service Plans • Internal Reporting • Several of these topics were included in our Residents Rights training module. • Director of Nursing Services personnel record will be updated on-going with a copy of all on-going in-services that are kept in her personnel record at Grace Barker Health. • The corrective action will be monitor to ensure the deficient practice will not reoccur through periodic audit review of personnel charts and updating annually all in-services that are required. • The corrective action will be to monitor to ensure the deficient practice will not recur through periodic audits on random staff charts and through inclusion in our QA/QI at each quarterly meetir	

ap 6/2/23

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S 190	Continued From page 4 2) Record review revealed Staff E, CNA/CMT, had a hire date of 02/03/2002. Personnel record review failed to reveal evidence Staff E received the following on-going in-service trainings in 2021: basic sanitation, food service, basic knowledge of cultural differences, safety, record-keeping, service plans, and internal reporting. Personnel record review failed to reveal evidence Staff E received the following on-going in-service trainings in 2022: emergency preparedness and procedures, resident elopement, basic sanitation, basic knowledge of cultural differences, personal assistance, medication assistance, body mechanics, record-keeping, service plans, and internal reporting. During an interview on 05/05/2023 at approximately 1:10 PM, the Executive Director was unable to provide evidence Staff D and E received on-going, at intervals not to exceed twelve (12) months, in-service training as appropriate for their job classifications and including the topics cited in § 2.4.12(G).	S 190		
S 270	Organization And Management 2.4.13(J) Management Of Services 2.4.13 (J) Smoking Policy 1. If the residence permits smoking, it shall have a policy that includes the following: a. Location of designated smoking area(s) separate from the common area; b. Prohibition of smoking in any area other than the designated area(s); c. Adequate ventilation in smoking areas;	S 270		

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S 270	Continued From page 5 d. Assessment (upon admission, quarterly, and when a significant change in function occurs) of all residents that smoke to ensure safe smoking capabilities. This Requirement is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the residence failed to complete a quarterly smoking assessment for two of two sample residents who smoke, ID #s 1 and 2. Findings are as follows: 1) Resident ID #1 was admitted to the residence in February of 2021. Record review revealed smoking assessments were completed on 02/08/2021, 02/03/2022, and 02/13/2023 for this resident. The record failed to reveal the resident was assessed quarterly as required. 2) Resident ID #2 was admitted to the residence in December of 2022. Record review revealed a singular smoking assessment dated 12/05/2022. The record failed to reveal the resident was assessed quarterly as required. During an interview on 05/05/2023 at approximately 2:00 PM, the Executive Director was unable to provide evidence the smoking assessments had been updated quarterly for these residents as required.	S 270	**S 270 Safe Smoking Assessment** 5/30/2023 • The corrective action which will be accomplished of those residents found to be affected by the deficient practice will be to immediately update all residents smoke assessments and ongoing quarterly assessments and update all Monthly Nurse Review, Services Plans and Assessments to reflect ongoing quarterly safe smoking assessments. • All residents have the potential to be affected by the deficient practice, so the above corrective action will affect all residents. • The corrective action will be to monitor to ensure the deficient practice will not recur through periodic audits on random residents charts and through inclusion in our QA/QI at each quarterly meeting. 6/2/23	
S 365	Residency Requirements 2.4.16(D) Resident Assessment/Service Plans	S 365		

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S 365	Continued From page 6	S 365		

2.4.16 (d) Resident Assessments and Service 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 surveyor observation, record review, and staff interview, it has been determined the residence failed to review the resident assessment at intervals not to exceed (12) months and each time a resident's condition changes significantly for one of three sample residents, ID #3.

Findings are as follows:

Review of a list of residents receiving outside services provided by the Executive Director on 05/05/2023 indicated ID #3 is receiving physical therapy (PT) services from an outside agency.

Record review revealed he/she was admitted to the residence in August of 2021, with diagnoses including, but not limited to: vertigo, ataxia (a degenerative disease of the nervous system that affects co-ordination, which causes difficulties with: balance, speech, and walking), and sleep apnea.

Surveyor observation of the resident's room at approximately 9:00 AM revealed a continuous positive airway pressure (CPAP) machine (CPAP therapy is a common treatment for obstructive sleep apnea which uses a hose connected to a mask or nosepiece to deliver constant and steady air pressure to help breathe while sleeping).

S 365 Resident Assessment/Service Plans 5/30/2023

- The corrective action which will be accomplished of those Residents found to have been affected by the deficient practice will be to document confirming all residents receiving outside services. Each Assessment and Service Plan of those affected residents have been updated immediately.
- All residents have the potential to be affected by the deficient practice so the the above corrective action will affect all residents receiving outside services.
- The corrective action will be to monitor all residents charts to ensure that the deficient practice will not recur through periodic audits on random residents charts and through inclusion in our QA/QI at each quarterly meeting .

5/24/23

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S 365	Continued From page 7 Record review of a nurse review dated 04/30/2023 states in part, "...Home Care for PT with walker..." Review of the resident's comprehensive assessment dated 07/19/2021 and updated on 08/01/2021, 08/31/2022, and 05/27/2023 failed to reveal PT services with a start of care of 04/02/2023. Additionally, this assessment indicated the resident does not have the cognitive ability to self-administer medications. The assessment was updated on "2/23" to reflect a CPAP machine. During an interview with the resident at approximately 12:05 PM, he/she indicated the staff assist with putting water in the CPAP machine, otherwise it is self-administered. During an interview on 05/05/2023 at approximately 3:45 PM, the Executive Director was unable to provide evidence the resident's comprehensive assessment had been updated with the addition of PT services and did not reflect the resident was self-administering the CPAP treatments.	S 365		
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.	S 390		

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S 390	Continued From page 8 This Requirement is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined the residence failed to review the service plan each time a resident's condition changes significantly and the plan accurately reflects the services provided by the residence for one of three sample residents reviewed, ID #3. Findings are as follows: Review of a list of residents receiving outside services provided by the Executive Director on 05/05/2023 indicated ID #3 is receiving physical therapy (PT) services from an outside agency. Record review revealed he/she was admitted to the residence in August of 2021, with diagnoses including, but not limited to: vertigo, ataxia (a degenerative disease of the nervous system that affects co-ordination, which causes difficulties with: balance, speech, and walking), and sleep apnea. Surveyor observation of the resident's room at approximately 9:00 AM revealed a continuous positive airway pressure (CPAP) machine (CPAP therapy is a common treatment for obstructive sleep apnea which uses a hose connected to a mask or nosepiece to deliver constant and steady air pressure to help breathe while sleeping). Record review of a nurse review dated 04/30/2023 states in part, "...Home Care for PT with walker..." The resident's comprehensive assessment was updated on "2/23" to reflect a CPAP machine. During an interview with the resident at	S 390	**S 390 Service Plans** **5/30/2023** • The corrective action which will be accomplished of those residents found to have been affected by the deficient practice will be to immediately update all residents Services Plans and Assessments to reflect outside services. • All residents have the potential to be affected by the deficient practice, so the above corrective action will affect all residents. • The corrective action will be to monitor to ensure the deficient practice will not recur through periodic audits of all residents charts and through inclusion in our QA/QI at each quarterly meeting. Residents Service Plans and Assessments will be updated annually if any outside services has been updated the service plans will be immediately updated with any significant change in condition. 4/27/23	

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S 390	Continued From page 9 approximately 12:05 PM, he/she indicated the staff assist with putting water in the CPAP machine, otherwise it is self-administered. Record review of the resident's service plan dated 08/31/2022 failed to reveal PT services from an outside agency and that the resident has a CPAP machine which he/she uses independently. During an interview on 05/05/2023 at approximately 3:50 PM, the Executive Director was unable to provide evidence the resident's service plan had been updated with the addition of PT services and did not reflect the resident was self-administering the CPAP treatments.	S 390		
S 545	Resident Care Services 2.4.24(A)(1) Medication Services 2.4.24 (A) Medication Services 1. For M1 and M2 licensure levels, each resident shall have the right to: a. Retain the services of his/her own personal physician and dentist; b. Select the pharmacy or pharmacist of his/her choice provided that the pharmacy or pharmacist supplies medications suitably packaged for the residence's program; c. Refuse any or all medications; d. Retain possession and control of his/her medications, provided that such possession and control is deemed safe by the resident, the resident's guardian, if appropriate, and the administrator or his/her designee in consultation	S 545		

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S 545	Continued From page 10 with the resident's physician(s). This Requirement is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined the residence failed to assess a resident to ensure a resident with possession and control of his/her medications was deemed safe by the resident, the resident's guardian, if appropriate, and the administrator or his/her designee in consultation with the resident's physician for two of two sample residents reviewed for self-administration of medication, ID #s 2 and 3. Findings are as follows: According to Brunner and Sudarth's textbook, Medical and Surgical Nursing, 7th Edition, 1992, p.524, "as with other medications, oxygen is administered with care, and its effects on each patient are carefully assessed. Oxygen is a drug and except in emergency situations is prescribed by a physician." 1) Record review revealed the residence to have a resident who is dependent on oxygen, ID #2. Record review revealed ID #2 was admitted to the residence in December of 2022 with diagnoses including, but not limited to: type II diabetes and chronic obstructive pulmonary disease (COPD). Review of ID #2's comprehensive assessment dated 11/29/2022 and updated on 12/02/2022 revealed the resident's primary reason for admission to be assistance with blood sugar monitoring. The assessment indicates the resident self-administers insulin. It also indicates the resident uses a nebulizer for breathing	S 545	**S 545 Residential Care Services and Medication Services 5/30/2023** • The corrective action which will be accomplished for those residents found to have been affected by the deficient practice • All residents have the potential to be affected by the deficient practice, so the above corrective action will affect all residents. • The corrective action will be monitored to ensure the deficient practice will not recur. Our Pharmacy of choice will provider medication review on site periodically on a regular basis. Medications will be checked for expiration dates. Expired Medications will be removed. All medications that have limited shelf life (eg. inhalers, eye drops, etc.) shall be appropriately dated and removed when expired. Periodic MAR audits will be done to ensure no expired or undated medications are being utilized.Staff will be in-serviced on these procedures. The Director of Nurses will perform periodic audits on random residents MAR charts and through inclusion in our QA/QI at each quarterly meeting. **Self Administered Medication/Treatments** • The corrective action which will be accomplished of those residents found to have been affected by the deficient practice will be to immediately update all residents requiring Assessment for Self Administered Medication/Treatments and a Physician's order to have on file for residents that will Self Administer Medication and Treatments. • All residents have the potential to be affected by the deficient practice so the above corrective action will affect all residents. • The corrective action will be to monitor to ensure the deficient practice will not recur through periodic audits of all residents charts and through inclusion in our QA/QI at each quarterly meeting. All Assessments, Service Plans, and Self Administer Medication Assessments have been updated immediately.	

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S 545	Continued From page 11 treatments as needed. Record review failed to reveal an assessment for the resident to self-administer oxygen, insulin, and nebulizer treatments. 2) Surveyor observation of Resident ID #3's room at approximately 9:00 AM revealed a continuous positive airway pressure (CPAP) machine (CPAP therapy is a common treatment for obstructive sleep apnea which uses a hose connected to a mask or nosepiece to deliver constant and steady air pressure to help breathe while sleeping). Record review revealed he/she was admitted to the residence in August of 2021, with diagnoses including, but not limited to: vertigo, ataxia (a degenerative disease of the nervous system that affects co-ordination, which causes difficulties with: balance, speech, and walking), and sleep apnea. The resident's comprehensive assessment was updated on "2/23" to reflect a CPAP machine. During an interview with the resident at approximately 12:05 PM, he/she indicated the staff assist with putting water in the CPAP machine, otherwise it is self-administered. Record review failed to reveal an assessment or a physician's order for the resident to self-administer the CPAP treatments. During an interview on 05/05/2023 at approximately 3:55 PM, the Executive Director was unable to provide evidence the residents were assessed to ensure they were deemed safe to self-administer medication in consultation with the resident's physician.	S 545		

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01383	A. BUILDING: _____ B. WING _____	05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 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.	S 565	S 565 Medication Services 5/30/2023 • The corrective action which will be accomplished of those residents found to have been affected by the deficient practice will be to immediately update all residents medications will be properly labeled with residents' names and directions for use of the medications. Medications and a Physician's order to have on file. • The corrective action which will be accomplished of those residents found to have been affected by the deficient practice will be to immediately update all residents medications that were found **expired.** Our Pharmacy of choice will provider medication review on site periodically on a regular basis. Medications will be checked for expiration dates. Expired Medications will be removed. All medications that have limited shelf life (eg. inhalers, eye drops, etc. shall be appropriately dated and removed when expired. Periodic MAR audits will be done to ensure no expired or undated medications are being utilized. Staff will be in-serviced on these procedures. The Director of Nurses will perform periodic audits on random residents MAR charts and through inclusion in our QA/QI at each quarterly meeting. All medications that are expired will be properly disposed of immediatel • All residents have the potential to be affected by the deficient practice so the above corrective action will affect all residents. • The corrective action will be to monitor to ensure the deficient practice will not recur through periodic audits of all residents charts and through inclusion in our QA/QI at each quarterly meeting. All Assessment, Service Plans, and Self Administer Medication Assessments have been updated immediately.	

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S 565	Continued From page 13 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, 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	S 565		

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S 565	Continued From page 14 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. l. 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 surveyor observation, record review and staff interview, it has been determined that the residence failed to ensure that medications shall be stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access for three of three sample residents reviewed for medication administration and the singular medication cart, 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 physician is responsible for directing medical treatment. Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm the clients..."	S 565		

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S 565	Continued From page 15 During surveyor observation on 05/05/2023 at approximately 8:30 AM, in the presence of Staff E, Certified Medication Technician (CMT)/Certified Nursing Assistant (CNA), the following medication discrepancies were identified: -Meclizine 25 mg (milligram) tablets for ID #1 with an expiration date of 04/15/2023 -Bisacodyl EC (enteric coated) 5 mg tablets for ID #1 with an expiration date of 01/20/2023 - Bisacodyl EC 5 mg tablets for ID #2 without a physician's order - Acetaminophen 325 mg tablet physician's order for ID #3, the medication was not available The following medications were found to be on the cart without a label of the directions for use and a resident's name, the only identifiers were room numbers on the bottles: -Vitality Gummies -Centrum Advanced Silver -Tylenol Regular Strength -Vitamin D Supplement -Tums Chewy Bites -Colace -2 Extra Strength Acetaminophen -2 Low Dose Aspirin -Once Daily Women's' Vite -Vitamin D3 Supplement -Extra Strength Biotin -Melatonin -B12 Supplement -Calcium + D3 During an interview on 05/05/2023 at approximately 4:20 PM, the Director of Nursing acknowledged all currently prescribed medication should be available for administration, expired	S 565		

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S 565	Continued From page 16 medications should not be available to be dispensed, discontinued medications should be removed from the medication cart, and all medications should be properly labeled.	S 565		
S 715	Physical Plant 2.4.30(K) Safety Requirements 2.4.30 (K) Safety Requirements K. Each residence shall develop written emergency plans related to internal and external disasters. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to develop written emergency plans related to internal and external disasters. Findings are as follows: Record review of the policy manual failed to reveal written contingency plans for common occurrences such as weather emergencies and in the event of an internal or external equipment failure. During an interview on 05/05/2023 at approximately 3:00 PM, the Executive Director was unable to provide evidence of these required policies and plans.	S 715	**S 715 Physical Plant Safety Requirement 5/30/2023** • The corrective action which will be accomplished for those residents found to have been affected by the deficient practice, all Policies and Procedures of safety requirements will be updated immediately for internal and external disasters. • All residents have the potential to be affected by the deficient practice so the above corrective action will affect all residents. • Residence will have a written updated contingency Policy and Procedure plan of action related to internal and external disasters. • The corrective action will be to monitor to ensure the deficient practice will not recur through periodic audits no less than annually of all Policy and Procedures and through inclusion in our QA/QI at each quarterly meeting. All Policies and Procedures will be updated immediate	