RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01506	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL RIDGE AT PROVIDENCE	700 SMITH STREET PROVIDENCE, RI 02908

(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 (22X211, 06/12/2023) were conducted at this residence. Deficiencies were identified relative to the licensure survey.	S 003	The filing of this Plan of Correction does not constitute an admission regarding the alleged finding, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.	

CMS 7/31/23

RECEIVED
JUL 25 2023
FACILITIES REGULATION

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: J. De La Roca — TITLE: Administrator — (X6) DATE: 7/25/23

RI Department of Health

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S 003	Initial Comments An unannounced biennial State Licensure survey and a complaint/incident investigation survey (QDN411, 06/12/2023) were conducted at this residence. Deficiencies were identified relative to the State Licensure survey.	S 003	S 230 A. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident ID#1 records were reviewed,	
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 the singular resident receiving wound care, ID #1. 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	and weekly wound measurements obtained from external wound clinician and placed in resident's record. Ongoing weekly wound clinicians visit notes will be obtained and placed in the resident's record. The communities ED and RCD and /or Designee will meet with the external visiting nurse organization to ensure ongoing weekly wound treatment notes will be documented and placed in the resident's record upon each visit. 7/3/23 B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: The community will conduct an audit to identify other residents with wounds C. What measures will be put into place and what systemic changes you will make to ensure that the deficient practice does not reoccur: Residents receiving wound care will be audited to ensure orders are in place. immediate and ongoing	6/15/2023 7/6/2023 6/15/2023 Immediate and ongoing

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

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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. Record review revealed ID #1 was admitted to the residence in September of 2022 with diagnoses including, but not limited to: anemia, hypertension, a history of left hip fracture, and atrial fibrillation (a type of abnormal heartbeat). Record review of the entrance conference list of residents receiving outside skilled services revealed ID #1 to be receiving skilled nursing (SN) services, physical therapy (PT), and occupational therapy (OT). During an interview with the Resident Care Director (RCD) and the Nurse Designee at that time, they indicated he/she is receiving skilled wound care. Additionally, they indicated the Resident goes to a wound clinic regularly for wound care.	S 230	D. How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur, (i.e., what quality assurance program will be put into place): The administrator and/or designee will audit residents receiving wound care weekly for 3 months to ensure orders are in place with the appropriate provider and will report findings to the Quality Assurance committee during quarterly meetings.	Immediate and ongoing

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S 230	Continued From page 2 Record review of ID #1's record failed to reveal documentation from the wound clinic. Additionally, the record failed to reveal any skin assessments performed by the residence. Review of the residence's chart notes for ID #1 revealed he/she had a fall with a left knee wound and a venous ultrasound to the left heel on 11/09/2022. Record review of ID #1's OT notes revealed a note dated 11/16/2022 which states in part, "...please wash lower legs + feet (don't get the bandage wet on L (left) heel)..." Additional record review of the residence's chart notes revealed he/she was unable to bear weight on 12/05/2023 and was sent out for evaluation. Record review of a Continuity of Care (COC) form dated 01/10/2023 from ID #1's primary care physician (PCP) revealed "wound left heel...wound evaluated + debrided Pts (patient's) care giver will perform daily dressing changes..." A communication to the OT provider from the PCP on 01/18/2023 indicates to elevate the left leg, continue with minimal walking and standing, and to off load the left heel when in bed. Record review of PT notes provided by the outside agency from 01/17/2023-06/08/2023 revealed ID #1 had a weight bearing restriction due to the left heel wound and was working on positioning of the left foot for pressure relief. On 04/20/2023 ID #1 had a skin graft to the left heel and was non-weightbearing post-surgical procedure until 04/27/2023. He/she then became weight bearing as tolerated (WBT) from 04/27/2023-05/25/2023.	S 230		

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S 230	Continued From page 3 Record review of skilled nursing notes dated 02/15/2023-06/07/2023 provided to the residence by the outside agency failed to reveal a description of the wound, staging of the wound, measurements of the wound, and all other pertinent information related to assessing the wound. Record review of wound clinic notes requested by the surveyor revealed the following: -03/29/2023 "...Wound has been present since about September or October 2022...Wound #1 Left Heel is a chronic Unstageable Pressure Injury...Initial wound encounter measurements are 1.8 cm (centimeter) length x 1.8 cm width x 0.2 cm depth ...area of 3.24 sq cm and a volume of 0.648 cubic cm. Adipose (tissue, otherwise known as body fat, is a connective tissue that extends throughout your body. It's found under the skin (subcutaneous fat), between the internal organs (visceral fat) and even in the inner cavities of bones (bone marrow adipose tissue) is exposed ...Post Debridement Measurements: 1.8 cm length x 1.8 cm width x 0.4 cm depth; with an area of 3.24 sq cm and a volume of 1.296 cubic cm...Home Health Care:...Please if able change dressing daily for 1-2 weeks ...optimal to prepare this wound for grafting..." -04/05/2023 "...Wound #1 Left Heel is a chronic Stage 3 Pressure Injury...status of Not Healed...measurements are 2 cm length x 1.9 cm width x 0.3 cm depth, with an area of 3.8 sq cm and a volume of 1.1 cubic cm...Adipose is exposed...Post Debridement Measurements: 2 cm length x 1.9 cm width x 0.4 cm depth; with an area of 3.8 sq cm and a volume of 1.52 cubic cm..."	S 230		

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S 230	Continued From page 4 -04/19/2023 skin graft application after debridement -05/31/2023 "...Wound #1 Left Heel is a chronic Stage 3 Pressure Injury...status of Not Healed...measurements are 1.2 cm length x 2 cm width x 0.6 cm depth, with an area of 2.4 sq cm and a volume of 1.44 cubic cm...Adipose is exposed...consider additional skin sub (substitute) applications if wound healed begins to stall again..." During an interview on 06/09/2023 at approximately 5:00 PM, the RCD acknowledged the residence did not assess ID #1's wounds, the documentation from the outside skilled nursing agency lacked the necessary assessment information, and the residence failed to have any documentation from the wound clinic regarding care provided.	S 230	S 285 A. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Sample Resident ID # 1: Community has reviewed current status and met with the Health Care Proxy to seek alternative placement.	6/14/23
S 285	Residency Requirements 2.4.14.A Residency Requirements 2.4.14 (A) Residency Requirements A. Each licensee, or his/her designee, through the assessment and evaluation procedures delineated in these regulations (see § 2.4.16(C) of this Part) shall be responsible to ensure that admission to and residency in an assisted living residence be limited to those individuals who meet the definition of "resident" in accordance with § 2.3(A)(32) of this Part. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined that the residence retained a resident that did not meet the definition of a	S 285	Status of resident ID# 1 Resident currently remains in the community. Resident ID#1 and her HCP were provided with written notice on 6/22/23. Continued conversations between the HPC, our community, and areas rehabs, and SNF's are ongoing with regard to alternative placement. There is a possibility that Resident ID # 1 may be able to transfer to an AL community Mass – a call is scheduled for 7/11/2023 regarding this. If that does not come to fruition, HCP stated he has a bed on hold at South County Nursing and rehab and a move could happen by weeks end. If the wound completely closes and heals, the intention would be for Resident ID # 1 to return to CRP.	Immediate and ongoing until placement has been found

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S 285	Continued From page 5 "resident" for the singular resident reviewed for wound care, ID #1. Findings are as follows: Per the Rules and Regulations for Licensing Assisted Living Residences the definition of a resident states in part, "'Resident' means an individual not requiring medical or nursing care as provided in a health care facility but who as a result of choice and/or physical or mental limitation requires personal assistance, lodging and meals and may require the administration of medication and/or limited health services...persons who are bedbound or in need of the assistance of more than one (1) person for ambulation are not appropriate to reside in assisted living residences...if the resident is under the care of a Rhode Island licensed hospice agency provided the assisted living residence assumes responsibility for ensuring that the required care is received...Notwithstanding the aforementioned, residents who are bed bound or in need of assistance of more than one (1) staff person for ambulation may reside in a residence if they are receiving hospice care in accordance with these regulations..." Per 2.4.1 (A)(4) of the regulation states "Any assisted living residence which offers to provide or provides services for residents receiving hospice services that are bed-bound or in need of assistance from more than one staff person for ambulation is required to be licensed at the F1 level, as defined in § 2.4.2(A)(1)(a) of this Part, and must have a license endorsement, issued pursuant to these regulations, to provide limited health services, and shall, at a minimum provide services for stage I and stage II pressure ulcer treatment and prevention and meet the	S 285	B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: RCD or Designee will audit residents who are under receiving skilled wound care and will ensure all meet the definition of a resident per the regulations. C. What measures will be put into place and what systemic changes you will make to ensure that the deficient practice does not reoccur: Nursing will be re-educated on S 285 Residency Requirements 2.4.14.A Residency Requirements.	6/15/2023 7/15/2023

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S 285	Continued From page 6 requirements of § 2.6 of this Part." Assisted living residences licensed to provide limited health services may provide stage I and stage II pressure ulcer treatment and prevention services. Pressure ulcers at stages III and IV have deeper involvement of underlying tissue with more extensive destruction. Stage III involves the full thickness of the skin and may extend into the subcutaneous tissue layer; granulation tissue and epibole (rolled wound edges) are often present. At this stage, there may be undermining and/or tunneling that makes the wound much larger than it may seem on the surface. Stage IV pressure ulcers are the deepest, extending into the muscle, tendon, ligament, cartilage or even bone. Pressure ulcers covered with slough or eschar are by definition "unstageable", as the base of the ulcer needs to be visible in order to properly stage the ulcer; as slough and eschar do not form on stage I pressure injuries or stage II pressure ulcers, the ulcer will reveal the wound to be either a stage III or stage IV pressure ulcer. This residence does not have a limited health service (LHS) license, thus is unable to provide any wound care to its' residents. Record review revealed ID #1 was admitted to the residence in September of 2022 with diagnoses including, but not limited to: anemia, hypertension, a history of left hip fracture, and atrial fibrillation (a type of abnormal heartbeat). Record review of the entrance conference list of residents receiving outside skilled services revealed ID #1 to be receiving skilled nursing (SN) services, physical therapy (PT), and occupational therapy (OT).	S 285	D. How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur, (i.e., what quality assurance program will be put into place): Residents assessed for move in will be reviewed by the administrator and/or RCD for appropriateness. Findings will be reported to the Quality Assurance Committee during quarterly meetings.	Immediate and ongoing

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S 285	Continued From page 7 During an interview with the Resident Care Director (RCD) and the Nurse Designee at that time, they indicated he/she is receiving skilled wound care. Additionally, they indicated the Resident goes to a wound clinic regularly for wound care. Record review of ID #1's record failed to reveal documentation from the wound clinic. Additionally, the record failed to reveal any skin assessments performed by the residence. Review of the residence's chart notes for ID #1 revealed he/she had a fall with a left knee wound and a venous ultrasound to the left heel on 11/09/2022. Record review of ID #1's OT notes revealed a note dated 11/16/2022 which states in part, "...please wash lower legs + feet (don't get the bandage wet on L (left) heel)..." Record review revealed the residence requested a variance for ID #1 on 11/20/2022 for skilled nursing services which were being provided for a left heel wound. The variance states in part, "...Resident has on 10/27/2022 noted with DTI (deep tissue injury (a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) resulting from prolonged pressure in an area of the body)..." A DTI is similar to an unstageable in the damage to the tissues is unable to be assessed but is more advanced than a stage I or II pressure ulcer. Additional record review of the residence's chart notes revealed he/she was unable to bear weight on 12/05/2023 and was sent out for evaluation.	S 285		

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S 285	Continued From page 8 Record review of a Continuity of Care (COC) form dated 01/10/2023 from ID #1's primary care physician (PCP) revealed "wound left heel...wound evaluated + debrided Pts (patient's) care giver will perform daily dressing changes..." A communication to the OT provider from the PCP on 01/18/2023 indicates to elevate the left leg, continue with minimal walking and standing, and to off load the left heel when in bed. Record review of PT notes provided by the outside agency from 01/17/2023-06/08/2023 revealed ID #1 had a weight bearing restriction due to the left heel wound and was working on positioning of the left foot for pressure relief. On 04/20/2023 ID #1 had a skin graft to the left heel and was non-weightbearing post-surgical procedure until 04/27/2023. He/she then became weight bearing as tolerated (WBT) from 04/27/2023-05/25/2023. Record review of skilled nursing notes dated 02/15/2023-06/07/2023 provided to the residence by the outside agency failed to reveal a description of the wound, staging of the wound, measurements of the wound, and all other pertinent information related to assessing the wound. Record review of wound clinic notes requested by the surveyor revealed the following: -03/29/2023 "...Wound has been present since about September or October 2022...Wound #1 Left Heel is a chronic Unstageable Pressure Injury...Initial wound encounter measurements are 1.8 cm (centimeter) length x 1.8 cm width x 0.2 cm depth ...area of 3.24 sq cm and a volume of 0.648 cubic cm. Adipose (tissue, otherwise known as body fat, is a connective tissue that	S 285		

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S 285	Continued From page 9 extends throughout your body. It's found under the skin (subcutaneous fat), between the internal organs (visceral fat) and even in the inner cavities of bones (bone marrow adipose tissue) is exposed ...Post Debridement Measurements: 1.8 cm length x 1.8 cm width x 0.4 cm depth; with an area of 3.24 sq cm and a volume of 1.296 cubic cm...Home Health Care:...Please if able change dressing daily for 1-2 weeks ...optimal to prepare this wound for grafting..." -04/05/2023 "...Wound #1 Left Heel is a chronic Stage 3 Pressure Injury...status of Not Healed...measurements are 2 cm length x 1.9 cm width x 0.3 cm depth, with an area of 3.8 sq cm and a volume of 1.1 cubic cm...Adipose is exposed...Post Debridement Measurements: 2 cm length x 1.9 cm width x 0.4 cm depth; with an area of 3.8 sq cm and a volume of 1.52 cubic cm..." -04/19/2023 skin graft application after debridement -05/31/2023 "...Wound #1 Left Heel is a chronic Stage 3 Pressure Injury...status of Not Healed...measurements are 1.2 cm length x 2 cm width x 0.6 cm depth, with an area of 2.4 sq cm and a volume of 1.44 cubic cm...Adipose is exposed...consider additional skin sub (substitute) applications if wound healed begins to stall again..." During an interview on 06/09/2023 at approximately 5:10 PM, the RCD acknowledged the residence did not assess ID #1's wounds and the residence failed to have any documentation from the wound clinic regarding care provided, thus did not have knowledge of the status of the wound or the resident's appropriateness to	S 285		

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S 285	Continued From page 10 remain residing there.	S 285	S 310	
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, 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;	S 310	A. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident ID# 1 -Records were reviewed and the community obtained wound assessments /progress noted from third party provider. Resident records are complete and accurate. B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: A community wide audit will be completed to ensure compliance.	7/5/2023 6/15/2023

QB 7/31/23

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(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 310	Continued From page 11 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; 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 the singular resident receiving wound care, ID #1.	S 310	C. What measures will be put into place and what systemic changes you will make to ensure that the deficient practice does not reoccur: Re-Education of S 310 Residency Requirement 2.4.15.A Resident Records will be provided to Nursing, the ED, RCD/Designee, and care managers. D. How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur, (i.e., what quality assurance program will be put into place): The RCD or Designee will conduct a random audit on resident records weekly for 3 months to ensure compliance with the regulation and will report findings to the Quality Assurance committee during quarterly meetings.	7/15/2023 Immediate and ongoing

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	ALR01506	A. BUILDING: _____ B. WING _____	06/12/2023

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S 310	Continued From page 12 Findings are as follows: Record review revealed ID #1 was admitted to the residence in September of 2022 with diagnoses including, but not limited to: anemia, hypertension, a history of left hip fracture, and atrial fibrillation (a type of abnormal heartbeat). Record review of the entrance conference list of residents receiving outside skilled services revealed ID #1 to be receiving skilled nursing (SN) services. During an interview with the Resident Care Director (RCD) and the Nurse Designee at that time they indicated the SN services are for wound care and a wound clinic also provides treatment to ID #1. Record review of skilled nursing notes dated 02/15/2023-06/07/2023 provided to the residence by the outside agency failed to reveal a description of the wound, staging of the wound, measurements of the wound, and all other pertinent information related to assessing the wound. Record review of a wound clinic note dated 03/29/2023 states in part, "...Wound has been present since about September or October 2022...Wound #1 Left Heel is a chronic Unstageable Pressure Injury..." A later note dated 04/05/2023 states in part, "...Wound #1 Left Heel is a chronic Stage 3 Pressure Injury...status of Not Healed..." These records were requested from the wound clinic by the surveyor. Record review of ID #1's record failed to reveal documentation from the wound clinic. Additionally, the record failed to reveal any skin	S 310		

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S 310	Continued From page 13 assessments performed by the residence. The resident's record also failed to reveal the current physician's order for the wound care being provided. During an interview on 06/09/2023 at approximately 5:00 PM, the RCD acknowledged the residence did not assess ID #1's wounds, the documentation from the outside skilled nursing agency lacked the necessary assessment information, the residence did not have the current physician's orders for wound treatments, and the residence failed to have any documentation from the wound clinic regarding care provided.	S 310	S 365 A. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident ID # 2 Assessment and Service plan have been updated to reflect current resident status.	6/9/2023
S 365	Residency Requirements 2.4.16.D Resident Assessment/Service Plans 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 record review and staff interview, it has been determined the residence failed to review the resident's comprehensive assessment at intervals not to exceed (12) months and each time a resident's condition changes significantly for three of six sample residents, ID #s 2,3, and 4. Findings are as follows:	S 365	Resident ID # 3 - Assessment and service plan have been updated to reflect current resident status and date. Resident ID # 4 - Assessment had been completed on 4/30/2023 and was awaiting family meeting for signature prior to being filed. Per family's request, the meeting occurred on 6/29/2023 due to POA having surgery. B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: A community wide audit will be conducted to ensure no other residents were affected by alleged deficient practice.	6/9/2023 6/29/2023 7/15/2023

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S 365	Continued From page 14 Review of a list of residents receiving outside services provided by the Nurse Designee on 06/08/2023 indicated ID #2 is receiving physical therapy (PT) and occupational therapy (OT) from an outside agency and is an active smoker, ID #3 is receiving OT, PT, and skilled nursing (SN) services, and ID #4 is receiving hospice services. 1) Record review revealed ID #2 was admitted to the residence in January of 2021 with diagnoses including, but not limited to: hypertension, difficulty walking, and frequent falls. Record review of ID #2's initial comprehensive assessment dated 01/20/2021 failed to reveal that the resident is an active smoker, all subsequent comprehensive assessments also fail to reveal this. Additionally, ID #2's comprehensive assessment dated 05/27/2023 failed to reveal the resident is receiving PT or OT, the service provider's notes indicate a start of care (SOC) of 03/15/2023 for PT and is ongoing. 2) Record review revealed ID #3 was admitted to the residence in May of 2022 with diagnoses including, but not limited to: degeneration of the lumbar spine, hypertension, and muscle wasting. Record review revealed the resident returned to the residence from a medical leave of absence on 05/04/2023. The Continuity of Care form dated 05/04/2023 from the skilled nursing facility had a referral to OT, PT, and SN services. Record review of the provision of care notes	S 365	C. What measures will be put into place and what systemic changes you will make to ensure that the deficient practice does not reoccur: Nursing, RCD, and Designee will be re-educated on s 365 Residency Requirements 2.4.16.D Resident Assessment/Service Plans D. How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur, (i.e., what quality assurance program will be put into place): The administrator or designee will audit to ensure compliance along with current assigned monthly chart audits for the next 90 days.	7/15/2023 Monthly for 90 days

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S 365	Continued From page 15 revealed ID # 3 had a SOC for OT services of 05/20/2023, a SOC for PT services of 05/08/2023, and a SOC for SN services of 05/05/2023. All services were ongoing. The readmission comprehensive assessment dated 05/04/2023 failed to reflect these outside service provisions. 3) Record review revealed ID #4 was admitted to the residence in April of 2022 with diagnoses including, but not limited to: malignant neoplasm of the liver, Alzheimer's disease, and congestive heart failure. Record review of hospice documentation revealed a SOC of 04/27/2023. Record review of ID #4's last comprehensive assessment dated 03/27/2023 failed to reveal being updated with the start of care for hospice services. During an interview on 06/09/2023 at approximately 3:00 PM, the Resident Care Director was unable to provide evidence Resident ID #s 2,3,and 4's comprehensive assessments had been updated as required.	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	S 390 A. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident ID # 2 Assessment and Service plan have been updated to reflect current resident status. Resident ID # 3 - Assessment and service plan have been updated to reflect current resident status. Resident ID # 4 - Assessment and service plan have been updated to reflect current resident status. B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: A community wide audit will be conducted to ensure no other residents were affected by alleged deficient practice.	6/30/2023 6/30/2023 6/30/2023 6/30/2023

7/31/23 CB

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S 390	Continued From page 16 This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined the residence failed to document a description of the services and interventions needed, including all services provided by outside healthcare agencies on the service plan for two of six sample residents, ID #s 2 and 4. Findings are as follows: Review of a list of residents receiving outside services provided by the Nurse Designee on 06/08/2023 indicated ID #2 is receiving physical therapy (PT) and occupational therapy (OT) from an outside agency and is an active smoker and ID #4 is receiving hospice services. 1) Record review revealed ID #2 was admitted to the residence in January of 2021 with diagnoses including, but not limited to: hypertension, difficulty walking, and frequent falls. Record review of ID #2's service plans dated 06/22/2022, 03/14/2023, and 05/27/2023 failed to reveal that the resident is an active smoker and the interventions required to maintain safe smoking. Additionally, ID #2's service plan dated 05/27/2023 failed to reveal the resident is receiving PT or OT, the service provider's notes indicate a start of care (SOC) of 03/15/2023 for PT and is ongoing. 2) Record review revealed ID #4 was admitted to the residence in April of 2022 with diagnoses including, but not limited to: malignant neoplasm of the liver, Alzheimer's disease, and congestive heart failure.	S 390	C. What measures will be put into place and what systemic changes you will make to ensure that the deficient practice does not reoccur: Nursing, RCD, and Designee will be re-educated on s 390 Residency Requirements 2.4.16.G.3 Resident Assessment/Service Plans D. How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur, (i.e., what quality assurance program will be put into place): The administrator or designee will audit to ensure compliance along with current assigned monthly chart audits for the next 90 days. chart audits weekly	7/15/2023 Monthly for 90 days

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S 390	Continued From page 17 Record review of hospice documentation revealed a SOC of 04/27/2023. Record review of ID #4's last service plan dated 03/27/2023 failed to reveal being updated with the start of care for hospice services. During an interview on 06/09/2023 at approximately 4:40 PM, the Resident Care Director was unable to provide evidence the service plans for ID #s 2 and 4 had been updated as required.	S 390	S 490	
S 490	Residential Care Services 2.4.21.C Dietetic Services 2.4.21 (C) Dietetic Services C. The food service in each residence shall comply with the appropriate requirements of R.I. Gen. Laws Chapters 21-27 and 21-31, Rhode Island Food Code (Part 50-10-1 of this Title), and such other applicable statutory or regulatory provisions. This Requirement is not met as evidenced by: Based on surveyor observations and staff interview, it has been determined that the residence failed to comply with the appropriate requirements of the Rhode Island Food Code. Findings are as follows: 1. The Rhode Island Food Code 2018 Edition 2-402.11 states in part, "...food employees shall wear hair restraints, beard restraints that are	S 490	A. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. Dining staff were provided with beard restraints, hair restraints and/or hats to be worn in the service areas of the kitchen. 2. RI Food Code 2018 Editions 3/501.16; The cold cut sandwich was discarded on 6/12/2023 and replaced. B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: The Dining Service Director will conduct random audits weekly to ensure compliance with S 490.	6/9/2023 6/9/2023 random weekly audits for 60 days

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S 490	Continued From page 18 designed and worn to effectively keep their hair from contacting exposed food..." During a surveyor observation on 06/08/2023 at approximately 3:20 PM of the main kitchen, Staff A, Cook, was observed without a beard restraint and hair restraint. During a surveyor observation on 06/09/2023 at approximately 11:45 AM Staff B and Staff C, Servers, were observed without hair restraints. During an additional surveyor observation on 06/09/2023 at approximately 11:45 AM, Staff D, Dishwasher, was observed without a beard restraint. 2. The Rhode Island Food Code 2018 Edition 3-501.16 states in part, "Time/Temperature Control for Safety Food, Hot and Cold Holding...food shall be maintained...at 5 degrees C (41 degrees Fahrenheit)..." During a surveyor observation of the lunch meal on the Harbor unit on 06/09/2023 at approximately 12:00 PM, the alternate meal selection of a cold cut sandwich had a holding cold temperature of 58 degrees Fahrenheit. During a surveyor interview on 06/09/2023 at approximately 2:20 PM, the Dining Services Director acknowledged the servers, dishwasher, and cook were not wearing hair and beard restraints. Additionally, he acknowledged the cold holding temperature of the cold cut sandwich was not within the acceptable cold holding temperature range.	S 490	C. What measures will be put into place and what systemic changes you will make to ensure that the deficient practice does not reoccur: Dining staff will be re-educated on safe food handling as stated by The Rhode Island Food Code 2018 Edition 2-402.11 and 3-501.16 D. How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur, (i.e., what quality assurance program will be put into place): Dining Service Director will complete random weekly audits for the next two months to ensure sustained compliance and findings will be brought to the quarterly Quality Assurance Committee Meeting.	7/15/2023 Random weekly audits for 60 days

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S 725	Continued From page 19	S 725	S 725	
S 725	Practices and Procedures, Violations, Sa 2.4.32.A Variance Procedure 2.4.32 (A) Variance Procedure A. The Department may grant a variance either upon its own motion or upon request of the applicant from the provisions of any rule or regulation in a specific case if it finds that a literal enforcement of such provision will result in unnecessary hardship to the applicant and that such a variance will not be contrary to the public interest, public health and/or health and safety of residents. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to obtain a variance for the singular established resident receiving wound care services, ID #1. Findings are as follows: Per the Rules and Regulations for Licensing Assisted Living Residences the definition of a resident states in part "... an established resident may receive daily skilled nursing care or therapy from a licensed health care provider for a condition that results from a temporary illness or injury for up to forty-five (45) days subject to an extension of additional days as approved by the Department, or if the resident is under the care of a Rhode Island licensed hospice agency provided the assisted living residence assumes responsibility for ensuring that the required care is received..." Record review revealed ID #1 was admitted to	S 725	A. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident ID #1 - The community will work with the resident and the HCP to transfer for appropriate placement. B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: A community wide audit will be completed to ensure all residents receiving wound care has obtained an approved variance.	6/14/2023 and ongoing until placement has been found. 6/14/2023

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S 725	Continued From page 20 the residence in September of 2022 with diagnoses including, but not limited to: anemia, hypertension, a history of left hip fracture, and atrial fibrillation (a type of abnormal heartbeat). Record review of the entrance conference list of residents receiving outside skilled services revealed ID #1 to be receiving skilled nursing (SN) services. During an interview with the Resident Care Director (RCD) and the Nurse Designee at that time they indicated the SN services are for wound care. Record review revealed the residence requested a variance for ID #1 on 11/20/2022 for skilled nursing services which were being provided for a left heel wound. The variance states in part, "...Resident has on 10/27/2022 noted with DTI (deep tissue injury (a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) resulting from prolonged pressure in an area of the body)..." A variance was not granted to the residence for this request due to a DTI being a more advanced wound than the residence's licensure allows. Record review revealed the resident remained in the residence continuing with skilled nursing services to present. During an interview on 06/09/2023 at approximately 1:00 PM, the Nurse Designee was unable to provide evidence of a variance granted by the Department for skilled nursing care being provided for greater than 45 days.	S 725	C. What measures will be put into place and what systemic changes you will make to ensure that the deficient practice does not reoccur: Nursing will be re-educated on S 725 Practices and Procedures, Violations, Sa 2.4.32A. Variance Procedure. D. How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur, (i.e., what quality assurance program will be put into place): The administrator or Designee will audit all residents receiving skilled nursing for wound care to ensure a variance request has been submitted and approved. Finding will be brought to QA committee quarterly meetings.	7/15/2023 Monthly for 90 days