RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01454	A. BUILDING: _____ B. WING _____	05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING VICTORIA COURT	55 OAKLAWN AVENUE CRANSTON, RI 02920

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S 003	Initial Comments An unannounced biennial State Licensure survey and a complaint/incident investigation survey (S8K011, from 5/30/2023 through 5/31/2023) were conducted at this residence. Deficiencies were identified relative to the State Licensure survey.	S 003	RECEIVED JUN 23 2023 FACILITIES REGULATION	
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	S 310	S 310 Residency Requirements 2.4.15 (A) Resident Records 2.4.15 (A) Resident Records Resident ID #1's resident record has been updated to include evidence of the services being provided by the outside agency. The evidentiary notes were emailed to RIDOH facilities regulations on 6/1/2023. Resident ID #1 sent to the hospital on 5/11/23 and transferred to a skilled nursing facility. Resident is no longer a resident of Pacifica Victoria Court. All residents with outside agency services have potential to be affected by this deficient practice. To ensure that this deficient practice does not recur, the executive director has a current list of all residents on outside services in her office and will review the resident/s status with the Resident Care Director weekly to include a checklist of therapeutic orders as required. In addition, the Resident Care Director has been re-inserviced on the community's policy and procedure pertaining to Home Health and Other Outside Agencies.(please see attached) The Executive Director met with the current outside agency professionals and inserviced them on the expections of completing the community's "Outside Agency/ Services Documentation" for each visit and to submit to the Resident Care Director prior to leaving the community. (please see attached form).	6/20/23

6/23/23

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Executive Director — TITLE — (X6) DATE: 6/20/2023

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S 310	Continued From page 1 agreement. 7. Written acknowledgments that the resident has signed and received copies of the rights as provided in R.I. Gen. Laws § 23-17.4-16; 8. Information about any specific health problems of the resident, which may be useful in a medical emergency, including diagnostic and/or therapeutic orders; 9. A record of personal property and funds which the resident has entrusted to the residence; 10. The name, address, and telephone number of a person identified by the resident who should be contacted in the event of an emergency or death of the resident and the name, address, and telephone number of the legal guardian; 11. Any other health-related emergency, or pertinent information which the resident requests the residence to keep on record; 12. A copy of the initial and periodic assessments described in § 2.4.16 of this Part; 13. A copy of the service plan and nurse review as described in § 2.4.16 of this Part; 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	S 310	Continued from page 1... The Executive Director and/or Resident Care Director will continue to audit all resident's records weekly, and/or as needed, for those residents who are receiving outside services to ensure that they include at a minimum therapeutic orders as required. The Executive Director has updated and emailed the representives of current outside agencies the expectations of the agency professionals completing the community's "Outside Agency/ Services Documentation" for each visit and to submit to the Resident Care Director prior to leaving the community.	6/20/23 6/20/23

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S 310	Continued From page 2 health problems of the resident, which may be useful in a medical emergency, including therapeutic orders for 1 of 8 sample residents reviewed, Resident ID #1. Findings are as follows: Record review revealed the resident moved into the residence in March of 2023 and has diagnosis including Alzheimer's disease. Record review revealed the resident received outside service for skilled nursing care related to wound care from 5/3/2023 through 5/11/2023. Record review failed to reveal evidence in the resident's record of the services being provided by the outside agency except for one progress note dated 5/5/2023. During a surveyor interview on 5/31/2023 at approximately 9:26 AM with the Residence Care Director, she acknowledged the resident was receiving outside service for wound care and acknowledged there was one progress note dated 5/5/2023 in the resident's record. Additionally, she could not provide evidence as to why the resident's record did not include at a minimum to include therapeutic orders as required.	S 310		
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	S 365	S365 Residency Requirements 2.4.16.D Resident Assessment/ Service Plans Resident ID #4 has a completed comprehensive assessment that has been updated to reflect the outside service the resident is receiving for physical therapy as of 5/17/2023.	6/7/23

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S 365	Continued From page 3 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 assessment at intervals not to exceed (12) months and each time a resident's condition changes significantly requiring outside services for 2 of 8 sample residents reviewed, Resident ID #4 and 7. Findings are as follows: Record review of a list of residents receiving outside services provided by the Residence Care Director on 5/30/2023 reveal Resident ID #4 is receiving physical therapy (PT) from an outside agency with a start of care date of 5/17/2023. Resident ID #7 is receiving skilled nursing care from an outside agency with a start of care date of 1/18/2023. 1. Record review revealed Resident ID #4 moved into the residence in March of 2023 and has diagnosis including cognitive impairment. Record review of a comprehensive assessment updated on 4/11/2023 failed to reveal evidence the assessment was updated to reflect the outside service the resident is receiving as of 5/17/2023. 2. Record review revealed Resident ID #7 moved into the residence in October of 2020 and has diagnosis including dementia. Record review of a comprehensive assessment updated on 1/27/2023 and 5/19/2023 failed to	S 365	Continued from page 3... Resident ID#7 has a completed comprehensive assessment that has been updated to reflect the outside service the resident received as of 1/18/2023. Resident is no longer a resident of this community and has moved to a skilled nursing facility. 6/19/2023 All resident assessments shall be reviewed and at intervals not to exceed twelve (12) months and each time a resident's condition changes significantly. The Resident Care Director will complete a new assessment on the RIDOH Approved Assessment Form for any resident prior to admission, at least annually and update as needed at change of condition including hospice, OT/ PT/ ST, and home health services. All residents have potential to be affected by this deficient practice. To ensure compliance and that this deficient practice does not recur, assessments will be audited by the Executive Director and/or Resident Care Director on a regular basis and each time there is a significant change of resident's condition. The Executive Director will meet with the Resident Care Director at least weekly to review any residents who are currently receiving outside agency services and meetings will be documented. 6/19/2023	

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S 365	Continued From page 4 reveal evidence the assessment was updated to reflect the outside service the resident received as of 1/18/2023. During a surveyor interview on 5/31/2023 at approximately 9:26 AM with the Residence Care Director, she could not provide evidence as to why the residents' assessments were not updated to reflect the outside services the residents were receiving.	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. 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 service plan each time a resident's condition changes significantly and failed to accurately reflect the residents are receiving outside services for 3 of 8 sample residents reviewed, ID #s 1, 4, and 7. Findings are as follows: 1. Record review revealed Resident ID #1 moved into the residence in March of 2023 and has diagnosis including Alzheimer's disease. Record review revealed Resident ID #1 received	S 390	S 390 Residency Requirements 2.4.16.G.3 Resident Assessment/ Service Plan 2.4.16 (G)(3) Service Plans Resident ID#1's service plan dated 3/27/2023 has been updated to reflect that the resident received outside service for skilled nursing care from 5/3/2023 through 5/11/2023 for wound care. Resident is no longer a resident of this community and has moved to a skilled nursing facility. 6/1/2023 Resident ID #4's service plan has been completed and updated to reflect the care the resident requires at this time and to include the outside service the resident is receiving with the start of care date. Resident ID#7's most recent service plan has been updated to reflect that the resident received outside service for skilled nursing care with a start date of 1/18/2023. Resident is no longer a resident of the community. All residents had potential to be affected by this deficient practice. 6/19/2023 To ensure that this deficient practice does not recur, service plans will be audited by the Executive Director on a regular basis and each time there is a significant change of resident's condition for continued compliance. .....continue to page 6	

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S 390	Continued From page 5 outside service for skilled nursing care from 5/3/2023 through 5/11/2023 for wound care. Record review of the resident's service plan dated 3/27/2023 failed to reveal evidence that the resident received the above-mentioned outside service. 2. Record review revealed Resident ID #4 moved into the residence in March of 2023 and has diagnosis including cognitive impairment. Record review revealed Resident ID #4 received outside service for physical therapy with a start of care date of 5/17/2023. Record review revealed the resident's service plan dated 3/6/2023 failed to reveal evidence that the resident is receiving physical therapy from an outside service. 3. Record review revealed Resident ID #7 moved into the residence in October of 2020 and has diagnosis including dementia. Record review revealed Resident ID #7 received skilled nursing care with a start of care date of 1/18/2023 from an outside service. Record review revealed the resident's service plan dated 1/27/2023 failed to reveal evidence that the resident received skilled nursing care from an outside service. During a surveyor interview on 5/31/2023 at approximately 9:26 AM with the Residence Care Director, she acknowledged the above-mentioned residents received outside services. Additionally,	S 390	Continued from page 5... The Executive Director will meet with the Resident Care Director at least weekly to review any residents who are currently receiving outside agency services and ensure service plans are updated as required. Quarterly audits by the regional director of operations will be completed to ensure compliance.	6/23/2023

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S 390	Continued From page 6 she acknowledged the residents service plans were not updated to reflect the outside services that they received.	S 390		
S 405	Residency Requirements 2.4.17.B Reporting Requirements 2.4.17 (B) Reporting Requirements B. Accidents, incidents, and medication errors resulting in out-of-residence emergency medical services resulting in a hospital admission of any resident shall be reported to the Center for Health Facilities Regulation in writing, via facsimile or electronic transmission to doh.ofr@health.ri.gov by the end of the next working day. A copy of each report shall be retained by the residence for review during subsequent inspections by the Department. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to report accidents and incidents resulting in out-of-residence emergency medical services which resulted in a hospital admission of any resident to the Center for Health Facilities Regulation in writing, by the end of the next working day for 1 of 2 residents with incidents, Resident ID #5. Findings are as follows: Record review revealed the resident had an unwitnessed fall on 4/7/2023 at 9:30 AM, which resulted in a hospital admission on 4/11/2023 due to a humeral head/neck fracture.	S 405	S 405 Residency Requirements 2.4.17.B Reporting Requirements 2.4.17 (B) Reporting Requirements Resident ID #5's incident report sent to Center for Health Facilties Regulations on 4/14/2023. All residents had potential to be affected by this deficient practice. To ensure that this deficient practice does recur, The Executive Director and Resident Care Director have been re-inserviced on the RIDOH Residency Requirements pertaining to section 2.4.17 (B) Reporting Requirements as well as re-inserviced on the company's policy and procedures pertaining to Internal Incident Report and State Incident Report. The Business Office Manager has also been trained on the RIDOH Residency Requirements pertaining to Reporting Requirements to ensure timely compliance. (please see attached) In addition, all reportable incidences must be submitted to the regional director of operations for continued compliance. Going forward, reporting of all accidents and incidents resulting in out-of-residence emergency medical services which resulted in a hospital admission of any resident will be reported to the Center for Health Care Facilities Regulation in writing by the end of the next business day.	6/19/2023

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S 405	Continued From page 7 Further record review revealed the resident was not transferred to the hospital following this incident until 4/11/2023. This resident's incident on 4/7/2023 resulting in a hospital admission on 4/11/2023 was reported to the Center for Health Facilities Regulations in writing on 4/14/2023. During a surveyor interview on 5/31/2023 at 11:20 AM with the Executive Director, she acknowledged the incident was not reported on the next working day as required.	S 405		
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 observation and staff interview, it has been determined that the residence failed to comply with the appropriate requirements of the Rhode Island Food Code in the café and in the kitchen service area. Findings are as follows: According to The Rhode Island Food Code 2018	S 490	S 490 Residential Care Services 2.4.21.C Dietetic Services 2.4.21 (C) Dietetic Services A complete deep cleaning of the cafe and of the noted service area was completed on to include the areas and items observed by the surveyor. The hose from the ice machine was corrected the next morning to expose an air gap in the drainage line after it was brought to the attention of the Executive Director. This correction was shown to the surveyor on 5/31/2023. All residents have potential to be affected by this deficient practice. To ensure compliance and that this deficient practice does not recur, the Food Service Director will continue to monitor the affected areas for cleanliness and sanitation and audit the Kitchen Cleaning Schedule for daily compliance. All dietary and dining staff will be retrained and inserviced on cleanliness and sanitation. The Food Service Director will continue to submit the monthly Kitchen Inspection Checklist to the Executive Director and to the corporate culinary food service director for monitoring of continued compliance.	5/30/2023 6/22/23

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S 490	Continued From page 8 Edition 4.601.11 states in part, "...nonfood contact surfaces of equipment shall be kept free of an accumulation of dirt...and other debris..." 1. During a surveyor observation of the cafe on 5/30/2023 at 11:50 AM revealed the following: - cabinets with stains dripping brown sticky matter on the cabinets and knobs. - brown matter on the microwave handle. - paper trash was thrown under the sinks' cabinet floor. - pink matter in the ice machine. - a drink fountain with a pink accumulation of a slippery liquid. According to the Rhode Island Food Code 2018 Edition 4.601.11 states in part, "...food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulation. 2. During a surveyor observation of the service area on 5/30/2023 at 11:55 AM revealed the following: - the toaster had a build up of crumbs that were stuck to the inside of the toaster in addition to the top of the toaster. - the plates that were ready for service contained food matter. - cups that were ready for service, stored adjacent to the dishwasher, contained crumbs.	S 490		

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S 490	Continued From page 9 Additionally, on top of the dish washing machine was an accumulation of brown matter. Furthermore, the entire wall and ceiling around the dish washing station had an accumulation of brown and black matter. According to The Rhode Island Food Code 2018 Edition 5-202.13 states in part, "an air gap between the water supply inlet and the flood level rim of the Plumbing Fixture, Equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (I inch)." 3. During a surveyor observation of the service area on 5/30/2023 at 11:55 AM revealed the hose from the ice machine was directly in the drain revealing that there was no air gap. During a surveyor interview with the Executive Director on 5/31/2023 at 12:40 PM following a tour of the cafe and the kitchen service area with two surveyors, she acknowledged the above mentioned observations.	S 490		
S 815	Special Care License Requirements 2.5.2.G Specific Requirements 2.5.2 (G) Specific Requirements G. The Alzheimer Dementia Special Care Unit/Program shall operate and provide services to all residents of the unit/program in accordance with the prevailing community standard of care for residents with the particular needs and behaviors with dementia	S 815	S 815 Special Care License Requirements 2.5.2.G Specific Requirements 2.5.2 (G) Specific Requirements Resident ID #1 is no longer a resident of this community and has moved to a skilled nursing facility. Resident ID#3's physician's order for weekly blood pressure monitoring has been discontinued. All residents have potential to be affected by this deficient practice. continue to page 11...	6/20/23

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S 815	Continued From page 10 This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to operate and provide services to all residents of the Special Care Unit (SCU) in accordance with the prevailing community standard of care for residents related to following physician's order for 2 of 8 sample residents reviewed, Resident ID #s 1 and 3. Findings are as follows: According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, "The physician is responsible for directing medical treatment, Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients." 1. Record review revealed Resident ID #1 moved into the residence in March of 2023. S/he has diagnosis including Alzheimer's disease. Record review of the resident's physician orders dated 5/8/2023 revealed an order which states in part, "Cleanse right hip ulceration [break in the skin] daily with NS [normal saline], apply bacitracin, cover with dry sterile dressing." Record review failed to reveal evidence of the resident receiving a dressing to his/her right hip daily on 5/9/2023 and 5/10/2023 as ordered. Record review of a progress note dated 5/12/2023 states in part, "[Resident] was sent out to the hospital last evening d/t [due/to] to right hip ulceration discover earlier this week..." 2. Record review revealed Resident ID #3 moved into the residence in July of 2018. S/he has	S 815	Continued from page 10... To ensure compliance and that this deficient practice does not recur, the Resident Care Director and/or delegate will perform an immediate audit of physician's orders with a primary focus on orders for medications that are associated with regular monitoring, such as blood pressure monitoring, and any order for the directing of medical treatment; the Resident Care Director will ensure that these orders are being followed and documented accordingly. 6/20/23 The Resident Care Director/ RN and medtechs will be retrained on the company's policy and procedures regarding medication and physician's orders. 6/22/23 The Resident Care Director will continue to submit to the Executive Director a monthly Medication Room Audit and Medication Administration Review log of at least 5 residents' records. 6/22/2023 (please see attached template) The Resident Care Director, or delegate, will review the Medication Administration Records (MARs) daily for continued compliance on the administration of medication to include monitoring. 6/20/23	

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PACIFICA SENIOR LIVING VICTORIA COURT	55 OAKLAWN AVENUE CRANSTON, RI 02920

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S 815	Continued From page 11 diagnoses including, but not limited to; dementia, hypertension (high blood pressure), and history of falls. Record review of the residents' physician orders revealed an order for blood pressure to be monitored weekly on Wednesday. Record review of the resident's April 2023 Medication Administration Record (MAR) failed to reveal evidence of the resident's blood pressure being monitored as ordered on 4/5/2023, 4/12/2023, 4/19/2023, and 4/26/2023, missing 4 out of 4 opportunities. Record review of the resident's May 2023 MAR failed to reveal evidence of the resident's blood pressure being monitored as ordered on 5/17/2023 and on 5/24/2023, missing 2 out of 4 opportunities. During a surveyor interview with the Residence Care Director on 5/31/2023 at 9:22 AM, she was unable to provide evidence as to why the physician order was not followed for Resident ID #1. During a subsequent interview on 5/31/2023 at 10:38 AM, she indicated that Resident ID #3 had low blood pressure at one time and that is why they were monitoring the resident's blood pressure. She was unable to provide evidence that the resident's blood pressure was monitored as ordered.	S 815		