RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01516	A. BUILDING: _____ B. WING _____	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENTWOOD BY THE BAY	4040 POST ROAD WARWICK, RI 02886

(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 biennial State Licensure survey and a complaint/incident investigation survey (4ZCL11, 08/02/2023) were conducted at this residence. Deficiencies were identified relative to the State Licensure survey.	S 003		
S 055	Licensure Requirements 2.4.3 Quality Assurance 2.4.3 Quality Assurance A. In accordance with R.I. Gen. Laws § 23-17.4-10.1, each assisted living residence shall develop, implement and maintain a documented, ongoing quality assurance program. 1. The purpose of this program shall be to attain and maintain a high quality assisted living residence through an on-going process of quality improvement that monitors quality, identifies areas to improve, methods to improve them, and evaluates the progress achieved. 2. Each licensed residence shall establish a quality improvement committee which shall include at least the following: assisted living administrator, registered nurse and a representative of dietary services. 3. The quality improvement committee shall meet at least quarterly; shall maintain records of all quality improvement activities; and shall keep records of committee meetings that shall be available to the Department during any onsite visit. 4. The quality improvement committee shall review and approve the quality improvement plan for the residence at intervals not to exceed twelve (12) months. Said plan shall be available to the	S 055	Corrective Action The Food Service Supervisor or designee from the Dietary department will be in attendance at all future Quality Assurance meetings. ID Residents No residents were identified by this citation. Systematic changes A sign-in sheet identifying the required staff (Director of Wellness, Administrator and Dietary Representative) will be developed and implemented for the meetings and signatures will be received from each at the beginning of every meeting. Monitor The Administrator will review the minutes and signature sheet each quarter to be sure that the requirement is being met.	09-15-23

8/21/23

RECEIVED
AUG 17 2023
FACILITIES REGULATION

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 8/10/23

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S 055	Continued From page 1 public upon request. 5. Each assisted living residence shall establish a written quality improvement plan that includes: a. Program objectives; b. Oversight responsibility (e.g., reports to the governing body, QI records); c. Includes methods to identify, evaluate, and correct identified problems; d. Provides criteria to monitor personal assistance and resident services, including, but not limited to: (1) Resident/family satisfaction; (2) Medication administration/errors; (3) Reportable incidents as specified in § 2.4.17 of this Part; (4) Resident falls; (5) Plans of correction developed in response to the Department ' s inspection reports. B. In addition to the requirements of §§ 2.4.3(A) (1) through (5) of this Part, all assisted living residences with a "dementia care" license and/or a "limited health services license" shall also address the following areas in their quality improvement plan: a. Prevention and treatment of decubitus	S 055		

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S 055	Continued From page 2 ulcers; b. Dehydration, and nutritional status and weight loss or gain; and c. Changes in mental or psychological status. 1. Quality improvement documentation shall be kept on file for a minimum of five (5) years. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to establish a quality improvement committee which shall include at least the Administrator, Registered Nurse, and a representative of dietary services. Findings are as follows: Record review of the quality assurance meeting minutes revealed there was not a representative of dietary services in attendance or serving on the committee as required on the following dates: 7/11/2023, 5/3/2023, 3/29/2023, 2/23/2023, 11/30/2022, 10/2/2022, 6/15/2022, and 5/4/2022. During a surveyor interview on 8/1/2023 at approximately 12:50 PM with the Director of Wellness and the Administrator, both staff acknowledged there was not a representative of dietary services in attendance on the above-mentioned dates, as required.	S 055		
S 365	Residency Requirements 2.4.16.D Resident Assessment/Service Plans	S 365		

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S 365	Continued From page 3 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 assessment at intervals not to exceed (12) months and each time a resident's condition changes significantly requiring outside services for 2 of 6 sample residents reviewed, Resident ID #s 1 and 2. Findings are as follows: Record review of a list of residents receiving outside services provided by the residence during the survey revealed the following residents are receiving outside services: 1. Record review revealed Resident ID #1 moved into the residence in June of 2021. S/he has diagnoses including history of a stroke and seizure. Record review revealed the last comprehensive assessment was completed on 6/19/2021. Record review failed to reveal evidence the assessment was reviewed annually for 2022 and 2023 as required. Additionally, the assessment failed to reveal the resident received occupational therapy in May of 2023 from an outside agency. 2. Record review revealed Resident ID #2 moved	S 365	Corrective Action The comprehensive assessment for Resident ID # 1 has been updated to include the occupational therapy services that were implemented, and it has been reviewed and updated as necessary for any additional changes. The comprehensive assessment for Resident ID # 2 has been updated to include the palliative management and wound care services that were implemented, and it has been reviewed and updated as necessary for any additional changes. 8/24/23 ID Residents A review of resident assessments has been conducted to be sure it includes any significant changes in condition (i.e. implementation of outside services) as well as evidence of an annual review/update of assessment. Systematic changes In addition to the current practice of updating resident service plans when there is a significant change in condition (i.e. implementation of outside services) as well as quarterly, the Director of Wellness or Designee will update the comprehensive assessment annually and when a there is a significant change in condition.	

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S 365	Continued From page 4 into the residence in June of 2021. S/he has diagnosis including peripheral vascular disease. Record review revealed the last comprehensive assessment was completed on 6/21/2021. Record review failed to reveal evidence the assessment was reviewed annually for 2022 and 2023 as required. Additionally, the assessment failed to reveal the resident received palliative management of chronic congestive heart failure with a start of care date of 2/10/2023 and is receiving skilled nursing service for wound care. During an interview on 8/1/2023 at approximately 2:13 PM with the Director of Wellness, she acknowledged the residents' comprehensive assessments were not reviewed annually, and updated to reflect the outside services provided as required.	S 365	(POC F365 continued) Monitor A random audit of the annual assessments will be conducted by the Director of Wellness to be sure that they have been reviewed and updated as required.	09-15-23