STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01426	A. BUILDING: _____ B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CIIY, STATE, ZIP CODE
THE PHYLLIS SIPERSTEIN TAMARISKALR	3 SHALOM DRIVE 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 (V4W011, 09/27/2023) were conducted at this residence. Deficiencies were identified relative to the State Licensure survey.	S 003		
s 205	Organization And Management 2.4.12.J.1 Administrative Management 2.4.12 (J) (1) Personnel Criminal Records Check 1. Pursuant to R.I. Gen. Laws§ 23-17.4-27, all employees of assisted living residences licensed under the Act, hired after September 30, 2014, and having routine contact with a resident or having access to a resident's belongings or funds shall undergo a national criminal background records check which shall include fingerprints submitted to the Federal Bureau of Investigation (FBI) by the Bureau of Criminal Identification of the Department of Attorney General. The national criminal records check shall be processed, prior to, or within one (1) week of employment. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined the residence failed to ensure that employees who have routine contact with a resident or have access to a resident's belongings or funds shall undergo a national criminal background records check prior to, or within one (1) week of employment, for 4 of 7 employees reviewed, Staff A, B, C, and D.	S 205	S205 Effective 7/1/2023 company policy requires that all new hires must complete a BCI review prior to hire date. All new hire records will be reviewed by Corporate HR and the ED prior to actual Start on site at the facility.	10/14/2023

Facilities Regulation

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

Helayne G Ramirez — ED — 10/16/2023

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S 205	Continued From page 1 Findings are as follows: Per the regulations which states in part, "...Pursuant to R.I. Gen. Laws§ 23-17.4-27, all employees of assisted living residences licensed under the Act, hired after September 30, 2014, and having routine contact with a resident or having access to a resident's belongings or funds shall undergo a national criminal background record check which shall include fingerprints submitted to the Federal Bureau of Investigation (FBI) by the Bureau of Criminal Identification of the Department of Attorney General. The national criminal records check shall be processed, prior to, or within one (1) week of employment..." 1. Personnel record review of Staff A revealed a hire date of 1/5/2023. This employee was hired as a Registered Nurse. Further record review revealed a copy of a national criminal background records check dated 1/24/2023 in her record. There is no evidence a national criminal background records check was completed prior to or within one week of hire, as required. 2. Personnel record review of Staff B, revealed a hire date of 3/21/2022. This employee was hired as a Certified Nursing Assistant (CNA). Further record review revealed a copy of a national criminal background records check dated 8/8/2022 in her record. There is no evidence a national criminal background records check was completed prior to or within one week of hire, as required. 3. Personnel record review of Staff C, revealed a hire date of 8/28/2020. This employee was hired as a CNA. Further record review revealed a copy of a national criminal background records check dated 7/22/2020 in her record. There is no	S 205		

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s 205	Continued From page 2 evidence a national criminal background records check was completed prior to or within one week of hire, as required. 4. Personnel record review of Staff D, revealed a hire dale of 4/19/2022. This employee was hired as a CNA. Further record review revealed a copy of a national criminal background records check dated 8/15/2022 in her record. There is no evidence a national criminal background records check was completed prior to or within one week of hire, as required. During an interview on 9/27/2023 at approximately 1:43 PM, the Administrator was unable to provide evidence of national criminal background checks for Slaff A, B, C, and D completed prior to or within one week of hire, as required.	S 205	S365 A full record audit of all resident records was completed. Waiver requests for the 4 memory care residents on Hospice was completed on 9/29/2023. All assessments and nursing notes are up to date reflecting the hospice care. We are moving to a new EMR system with Residex software effective 11-1-2023. Built into the system are prompts for annual assessment and quarterly reviews of IPCCs In addition there will be additional assessment documentation reflecting any changes in condition, with goals, interventions and effect. The ED and the RCD are responsible to complete a monthly audit of 10% of resident records. To be reviewed in quarterly Qapi meetings. See attached audit tool.	10/14/23
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 have a comprehensive assessment of the resident's health, physical, social, functional, activity, and cognitive needs. Additionally, the residence failed to review the resident's comprehensive	S 365		

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S 365	Continued From page 3 assessment at intervals not to exceed twelve (12) months and each time a resident's condition changes significantly for 4 of 7 sample residents reviewed, Resident ID #s 4, 5, 6, and 7. Findings are as follows: **1.** Record review revealed Resident ID #4 moved into the residence in October of 2022 with a diagnosis of dementia. Record review revealed the resident is receiving hospice services with a start of care date of 7/29/2023. Record review of the resident's comprehensive assessment dated 7/6/2023 failed to reveal evidence the assessment was updated to reflect that the resident received the above-mentioned outside services. 2. Record review revealed Resident ID #5 moved into the residence in April 2023 with a diagnosis of dementia. Record review revealed the resident is receiving hospice services with a start of care date of 6/9/2023. Record review of the resident's comprehensive assessment dated 9/16/2023 failed to reveal evidence the assessment was updated to reflect that the resident received the above-mentioned outside services. 3. Record review revealed Resident ID #6 moved into the residence in December of 2020 with a diagnpsis of dementia. Record review revealed the resident is receiving	S 365		

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S 365	Continued From page 4 hospice services with a start of care date of 12/12/2022. Record review of the resident's comprehensive assessment dated 8/5/2023 failed to reveal evidence the assessment was updated to reflect the resident received the above-mentioned outside services. 4. Record review revealed Resident ID #7 moved into the residence in October of 2014 with a diagnosis of cognitive decline. Record review revealed the resident is receiving hospice services with a start of care date of 9/15/2023. Record review failed to reveal evidence that a comprehensive assessment was completed, as required. During a surveyor interview on 9/27/2023 at approximately 10:15 AM with the Director of Wellness, she could not provide evidence an assessment was completed for ID #7. Additionally, she could not provide evidence assessments were updated for Resident ID #s 4, 5, and 6, as required.	S 365	S375 A full record audit of all resident records was completed. All resident Assessments and service plans have been brought up to date. All resident or designee signatures will be obtained by year end.	10/14/2023 12/30/2023
S 375	Residency Requirements 2.4.16.F Resident Assessment/Service Plans 2.4.16 (F) Nurse Review 1. Nurse review is necessary for all levels of licensure. a. A registered nurse shall visit the residence at least once every thirty (30) days except as	S 375	We are moving to a new EMR system, Residex Software effective 11/1/2023. Built into the system are prompts for annual assessment and quarterly reviews of IPCCs In addition there will be additional assessment documentation reflecting any changes in condition, with goals, interventions and effect. The ED and RCD will complete monthly audits of 10% of records for presentation to QAPI.	

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S 375	Continued From page 5 provided in§ 2.4.16(F)(1)(b) of this Part and shall complete a review to include the following: (1) Monitor the medication regimen for all residents; (2) Review any new physician orders and evaluate the health status of all residents by identifying symptoms of illness and/or changes in mental/physical health status; (3) Evaluate the appropriateness of placement for each resident; **(4)** Make any necessary recommendations to the administrator; (5) Follow up on previous recommendations; (6) Provide a signed, written report **in** the residence documenting: (AA) Date and time of assessment; (BB) Recommendations for follow-up; (CC) Progress on previous recommendations; (DD) Verification that the medication listed by the pharmacist on the mediset, blister pack or medication container is current with physician orders **(M-1** level only); (EE) Physical assessment identifying symptoms of illness and/or changes in mental or	S 375		

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S 375	Continued From page 6 physical health status and appropriateness of placement; (FF) Such reports shall be on file at the residence. (7) Complete the quarterly evaluation of the residence's registered medication aide(s) administration of medication. (Approved Department form is available for downloading online). b. In those residences that have one or more licensed registered nurses (i.e., at least one full-time equivalent equal to thirty-five (35) hours) on- site, the nurse review shall be completed at least once every ninety (90) days. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to complete nurse reviews every 90 days as required for 4 of 7 sample residents reviewed, Resident ID #s 4, 5, 6, and 7. Findings are as follows: 1. Record review revealed Resident ID #4 moved into the residence in October of 2022 with a diagnosis of dementia. Record review failed to reveal evidence a nurse review was completed every 90 days as required since his/her move-in date of October 2022. 2. Record review revealed Resident ID #5 moved into the residence in April of 2023 with a diagnosis of dementia.	S 375		

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S 375	Continued From page 7 Record review failed to reveal evidence a nurse review was completed every 90 days as required since his/her move in date of April 2023. 3. Record review revealed Resident ID #6 moved into the residence in December of 2020 with a diagnosis of dementia. Record review revealed the resident's last 90-day nurse review was completed on 12/28/2022. 4. Record review revealed Resident ID #7 moved into the residence in October of 2014 with a diagnosis of dementia/cognitive decline. Record review revealed the resident's last 90-day nurse review was completed on 10/30/2022. During a surveyor interview on 9/27/2023 at approximately 1:32 PM with the Director of Wellness, she was unable to provide evidence that 90-day nurse reviews had been completed for the above-mentioned residents, as required.	S 375		
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	S390		

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S 390	Continued From page 8 the service plan at intervals not to exceed twelve (12) months and each time a resident's condition changes significantly. Additionally, the service plans failed to accurately reflect that the residents are receiving outside services for 4 of 7 sample residents reviewed, Resident ID #s 4, 5, 6, and 7. Findings are as follows: 1. Record review revealed Resident ID #4 moved into the residence in October of 2022 with a diagnosis of dementia. Record review revealed the resident is receiving hospice services with a start of care date of 7/29/2023. Record review of the resident's service plan dated 7/6/2023 failed to reveal evidence that the service plan was updated to reflect that the resident is receiving the above-mentioned outside service. 2. Record review revealed Resident ID #5 moved into the residence in April 2023 with a diagnosis of dementia. Record review revealed the resident is receiving hospice services with a start of care date of 6/9/2023. Record review of the resident's service plan dated 8/29/2023 failed to reveal evidence that the service plan was updated to reflect that the resident is receiving the above-mentioned outside service. 3. Record review revealed Resident ID #6 moved into the residence in December of 2020 with a diagnosis of dementia.	S 390		

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S 390	Continued From page 9 Record review revealed the resident is receiving hospice services with a start of care date of 12/12/2022. Review of the resident's record failed to reveal evidence that a service plan was developed, reviewed at an interval not to exceed 12 months, and updated to reflect that the resident is receiving the above-mentioned outside service. 4. Record review revealed Resident ID #7 moved into the residence **in** October of 2014 with a diagnosis of dementia/cognitive decline. Record review revealed the resident is receiving hospice services with a start of care date of 9/15/2023. Record review of the resident's service plan dated 1/23/2023 failed to reveal evidence that the service plan was updated to reflect that the resident is receiving the above-mentioned outside service. During a surveyor interview on 9/27/2023 at approximately 1O:12 AM with the Director of Wellness, she could not provide evidence a service plan was developed for ID #6. Additionally, she could not provide evidence service plans were updated for ID #s 4, 5, and 7, as required.	S 390		
S 450	Licensure Requirements 2.4.18 Rights of Residents 2.4.18 Rights of Residents A. Every assisted living residence for adults licensed pursuant to these regulations shall	S450	S450 The identifying information regarding Residents and staff was removed from prior survey posting immediately upon inspection. The ED will assure that confidentiality is maintained in any future survey result posting.	9/27/2023

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S 450	Continued From page 10 observe the standards stated in R.I. Gen. Laws § 23-17.4-16, "Rights of Residents" and such other appropriate standards as may be prescribed in rules and regulations promulgated by the Department with respect to each resident of the residence. B. For purposes of the following standards stated in§§ 2.4.18(8)(1) through (7) of this Part the term "resident" shall also mean the resident's agent as designated in writing or legal guardian. 1. Upon request have access to all records pertaining to the resident, including clinical records, within the next business day or immediately in emergency situations; 2. Upon admission and during the resident's stay be fully informed in a language the resident understands, of all resident rights and rules governing resident conduct and responsibilities; a. Each resident shall receive a copy of their rights. b. Each resident shall acknowledge receipt in writing; and c. Each resident shall be informed promptly of any changes. 3. Be informed in writing, prior to, or at the time of admission or at the signing of a residential contract or agreement of: a. The scope of the services available through the residence's service program, including health services, and of all related fees and charges, including charges not covered either under	S450		

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s 450	Continued From page 11 federal and/or state programs by other third party payers or by the residence's basic rate; b. The residence's policies regarding overdue payment including notice provisions and a schedule for late fee charges; c. The residence's policy regarding acceptance of state and federal government reimbursement for care in the residence both at time of admission and during the course of residency if the resident depletes his or her own private **resources;** d. The residence's criteria for occupancy and termination of residency agreements; e. The residence's capacity to serve residents with physical and cognitive impairments; f. Support any health services that the residence includes in its service package or will make appropriate arrangements to provide these services; 4. Upon provision of at least thirty (30) days notice, if a resident chooses to leave a residence, the resident shall be refunded any advanced payment made provided that the resident is current in all payments; 5. The residence can discharge a resident only for the following reasons and within the following guidelines: a. Except in life-threatening emergencies and for nonpayment of fees and costs, the residence gives thirty (30) days' advance written notice of termination of residency agreement with a	S450		

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s 450	Continued From page 12 statement containing the reason, the effective dale of termination, the resident's right to an appeal under state law, and the name/address of the State Ombudsperson's office; b. If resident does not meet the requirements for residency criteria stated in the residency agreement or requirements of slate or local laws or regulations; c. If resident is a danger to self or the welfare of others; and the residence has attempted to make a reasonable accommodation without success to address resident behavior in ways that would make termination of residency agreement or change unnecessary; which would be documented in the resident's records; d. For failure to pay all fees and costs stated in the contract, resulting in bills more than thirty (30) days outstanding. A resident who has been given notice to vacate for nonpayment of rent has the right to retain possession of the premises, up to any time prior to eviction from the premises, by tendering to the provider the entire amount of fees for services, rent, interest, and costs then due. The provider may impose reasonable late fees for overdue payment; provided that the resident has received due notice of such charges in accordance with the residence's policies. Chronic and repeated failure to pay rent is a violation of the lease covenant. However the residence must make reasonable efforts to accommodate temporary financial hardship and provide information on government or private subsidies available that may be available to help with costs; and e. The residence makes a good faith effort to	S 450		

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S 450	Continued From page 13 counsel the resident if the resident shows indications of no longer meeting residence criteria or if service with a termination notice is anticipated; 6. To be able to share a room or unit with a spouse or other consenting resident of the residence in accordance with terms of the resident contract; 7. To live in a safe and clean environment. C. In addition to the standards stated in R.I. Gen. Laws§ 23-17.4-16, residents are entitled to the following: 1. Receive dental services from a dentist of his/her choice; 2. Each resident shall be given, in writing, the names, addresses, and telephone numbers of: the Department; the Medicaid Fraud and Patient Abuse Unit of the Department of Attorney General; the State Ombudsperson; and local police offices. D. The residence must: 1. Implement written policies and procedures to ensure that all residence employees are aware of and protect the resident's rights contained in these regulations; 2. Have prominently displayed a posting of the most recent state licensing survey of the assisted living residence; and 3. Provide each resident or his or her representative upon admission, a copy of the	S450		

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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 450	Continued From page 14 provisions of§ 2.4.18 of !_his Part and shall display in a conspicuous place on the premises a copy of the "Rights of Residents." This Requirement is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined the residence failed to implement written policies and procedures to ensure that all of the residence's employees protect the residents' rights contained in these regulations and to observe the standards stated in R.I. Gen. Laws§ 23-17.4-16 (a)(2)(ix) relative to identifying information for the 16 residents listed in the facility's survey results documents located in the main lobby area, ResidentID#s4, 6, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19,20,and21. Findings are as follows: Copies of state licensing survey results, including identifying information of residents, were observed on 9/27/2023 at approximately 9:55 AM in the residence's main entrance/lobby area: 1. "Resident/Staff Roster' form dated 11/14/2022 with two residents identified, ID #s 4 and 6 and a copy of ID #4's comprehensive assessment and. service plan. 2. "Resident/Staff Roster" form dated 10/24/2022 with four residents identified, ID #s 8, 9, 10, and 11. 3. "Resident/Staff Roster" form dated 10/19/2021 with ten residents identified, ID #s 12, 13, 14, 15, 16, 17, 18, 19, 20, and 21.	S 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01426	A. BUILDING: _____ B. WING	09/27/2023

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S 450	Continued From page 15 During a surveyor interview on 9/27/2023 at approximately 11:58 AM with the Executive Director, she acknowledged the above observations.	S450		
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, record review, 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: According to the Rhode Island Food Code 2018 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 main kitchen on 9/26/2023 at approximately 9:35 AM in the presence of the Food Service Director (FSD), revealed the hood compartments above the stove a heavy accumulation of black substance and an accumulation for brownish liquid dripping from the	S490	S490 1. A weekly cleaning schedule was implemented on 9/27/2023. Staff initial a cleaning log after cleaning. All cook staff were educated. 2. Scoops were removed from containers on 9/27/2023. All cook staff were educated about contamination and appropriate storage of scoops. 3. All inadequately labeled/dated food items were removed from any type of storage. All staff were educated regarding appropriate storage and the requirement to label and date all open items. 4. The temperature booster was replaced on the dishwasher and daily temp logs are being kept to assure reaching the correct temperature on the dishwasher. The FSD is responsible for on going compliance and presentation of logs at Quarterly QAPI meetings.	10/14/2023

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s 490	Continued From page 16 parameter of the hood. According to the Rhode Island Food Code 2018 Edition 304.12 states in part, "...In-Use Utensils, Between-Use Storage. During pauses in FOOD preparation or dispensing, FOOD preparation and dispensing UTENSILS shall be stored: (A) Except as specified under (B) of this section, in the FOOD with their handles above the top of the FOOD and the container; (B) In FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD with their handles above the top of the FOOD within containers or EQUIPMENT that can be closed, such as bins of sugar, flour, or **cinnamon.."** 2. During a surveyor observation of the dry food storage room on 9/26/2023 at approximately 9:40 AM in the presence of the FSD, revealed three large containers of flour, sugar, and coco powder with scoops stored inside the container lying directly on these food items. According to Section 3-501.17 of Rhode Island Food Code states in part" (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under§ 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO -EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5'C (41'F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT	S490		

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s 490	Continued From page 17 TIMEfTEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety..." 3. During a surveyor observation of two standup refrigerators in the main kitchen on 9/26/2023 at approximately 9:48 AM revealed the following: - A container of tomatoes sauce dated 9/13 - A container of cooked pasta not dated - A container of a thick brown liquid, without a label and not dated - A container of cooked mushroom not dated - A container of broth not dated - A plate of cooked salmon not dated - Two containers of cooked chicken not dated - A container of cooked chicken dated 9/18 - A container of chopped celery in a liquid content, not dated - A container of cooked chopped liver dated 8/22 - A container of tuna salad not dated - A container of caramelized onion not dated According to section 4-501.112 of the Rhode Island Food Code edition 2018 states in part, "Mechanical Warewashing Equipment, Hot Water	S 490		

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s 490	Continued From page 18 Sanitization Temperatures. (A)...the temperature of the fresh hot water sanitizing rinse as it enters the manifold may not be more than 90 [degrees] F [Fahrenheit], or less than...(2) For all other machines, 82 [degrees] C (180 [degrees] F)..." 4. During a surveyor observation of the dish washing process on 9/26/2023 at approximately 11:45 AM in the presence of a utility staff, Staff E, the hot water dish washing machine reached a temperature of 174 degrees Fahrenheit for two of the four times observed, and 176 degrees Fahrenheit for two times during the sanitizing rinse circle, which is less than the required temperature needed for sanitization. During an interview immediately following this observation, Staff E acknowledged the dish washing machine did not reach the required temperature for sanitization. During an interview on 9/26/2023 at 11:50 AM with the FSD, he acknowledged the above-mentioned food items were not stored appropriately as required. Additionally, he could not provide evidence why the dish washing machine did not reached the required sanitization temperature.	S490		
s 555	Residential Care Services 2.4.24.A.3.a Medication Services 2.4.24 (A) (3) (a) Medication Services 3. Each residence shall provide medication services only in accordance with the appropriate level of licensure for which the residence is licensed, which shall be as follows: a. For assisted living residences licensed at	S 555		

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s 555	Continued From page 19 the M2 Level, assistance with self- administration by unlicensed employees means that the residence shall only be responsible for reminding residents to take medications, and: (1) The resident or guardian must provide written authorization for the residence to provide assistance with the self-administration of medications; (2) The residence must provide, in writing, a description of services provided by the residence to each physician prescribing for a resident, including limitations on services; (3) Employees may only remind the resident and observe the self- administration of medication; (4) The resident shall not require nursing assessment of health status before receiving the medication, nor nursing assessment of the therapeutic or side effects after the medication is taken; (5) Except as provided in§ 2.4.24(A)(3)(a)(7) of this Part, the medication shall be in the original pharmacy-dispensed container with proper label and directions attached; (6) Unlicensed employees shall not monitor health indicators, make medication decisions, adjust medications or provide other medical or nursing decisions; (7) For residents capable of self-administration of medication but who wish to ask assisted living residence employees to use a medi-set (pre-poured packaging distribution	S 555		

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S 555	Continued From page 20 system), only registered medication aide, licensed nurse, or pharmacist shall organize the medications for up to one **(1)** week; (8) All medication in the residence, regardless of whether controlled by employees or by the resident, shall be stored securely. All medications shall be stored in a manner to prevent spoilage, dosage errors, administration errors or inappropriate access by other residents, visitors, or unauthorized employees. Provisions for safe storage may include lockable containers, secure spaces, or lockable units, as ,appropriate to the residence and the resident population. (9) There shall be documented policies or procedures regarding medication disposal and inventory procedures in the policies and procedures manual. (10) Each person assisting residents with self-administration of medications shall: (AA) Be an employee of the residence; (BB) Be literate in English; and (CC) Receive orientation, instruction and on-the-job training regarding relevant policies and procedures; or (DD) Be a licensed nurse. (EE) M2 level facilities may limit record keeping for residents who retain possession and control of medications to the requirements of§ 2.4.15(A)(6) of this Part.	S 555		

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s 555	Continued From page 21 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, or inappropriate access for 2 of 3 medication carts observed.• Findings are as follows: 1. During a surveyor observation of the first-floor medication cart on 9/26/2023 at approximately 10:30 AM in the presence of a Certified Medication Technician (CMT), Staff F, revealed the following medications without a resident identifier and directions for use: - Vitamin 03 1000 IU (international unit) -Aspirin 81 MG (milligram) - Pro-stat liquid protein - Polyethylene Glycol 3350 MG - Tylenol Extra Strength 500 MG During an interview immediately following this observation, Staff F, acknowledged the above-mentioned medications did not have residents' identifiers and directions for use. 2. During a surveyor observation of the second-floor medication cart on 9/26/2023 at approximately 12:55 PM in the presence of a CMT, Staff G, revealed a Basaglar U-100 insulin pen, opened, not dated, without a resident identifier, and directions for use. Manufacturer instructions indicate to discard the insulin pen 28 days after opening. Additional observation of this medication cart	S 555	S555 All medication carts have been audited for labeling for a resident identifier and directions for use. Medications were labeled or discarded. Medication carts will be audited weekly for 4 weeks and then monthly. The audits will be reviewed at Quarterly QAPI meetings. The RCD is responsible for the completion or the audits.	10/14/2023

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S 555	Continued From page 22 revealed a Wixela inhaler and a Fluticasone Propionate inhaler, opened and not dated. Manufacturer instructions indicates to discard the inhalers one month after opening. During an interview immediately following this observation, Staff G, acknowledged the insulin pen was opened and not dated, did not have a resident identifier, and directions for use. Additionally, she acknowledged the inhalers were opened and not dated. During a surveyor interview on 9/26/2023 at approximately 1:52 PM, the Director of Wellness could not provide evidence the above-mentioned medications were stored appropriately, as required.	S 555		
S 705	Physical Plant 2.4.30.I Safety Requirements 2.4.30 (I) Safety Requirements I. Each residence shall develop and maintain a written plan and procedure for the evacuation of the premises in case of fire or other emergency, based on F1 / F2 licensure requirements, Fire Safety Code-General Provisions (R.1. Gen. Laws Chapter 23-28.1) requirements. 1. Emergency steps of action shall be clearly outlined and posted in conspicuous locations throughout the residence. 2. Drills simulating fire emergencies, testing the effectiveness of the fire evacuation plan shall be conducted at least six (6) times per year on a bimonthly basis with a minimum of two (2) drills conducted during the night when residents are sleeping with documentation of observed ability of	S 705	S705 The fire drill calendar for the year has Been developed ensuring a fire drill on Each shift occurs quarterly. 50% of the drills will simulate a real emergency with an obstruction mimicking a real emergency, e.g blocked exit. See enclosed calendar. The Maintenance Director is responsible for holding the drills, completing documentation describing the drill and performance during the drill and getting sign off by all participants.	10/14/2023

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S 705	Continued From page 23 residents to carry out evacuation procedures. At least fifty percent (50%) of these drills shall be obstructed drills, as defined in Fire Safety Code-General Provisions (R.I. Gen. Laws Chapter 23-28.1). 3. The drills shall be permitted to be announced in advance to the residents. The drills shall involve the actual evacuation of all residents to an assembly point as specified in the emergency plan and shall provide residents with experience in egressing through all exits and means of escape required by the Fire Safety Code-General Provisions (R.I. Gen. Laws Chapter 23-28.1). Exits and means of escape not used in any fire drill shall not be credited in meeting the requirements of the Fire Safety Code-General Provisions (R.I. Gen. Laws Chapter 23-28.1). a. Documentation of fire drills shall be maintained and shall include no less than the following information: (1) Name of the person conducting the drill; (2) Date and time of the drill; (3) Amount of time taken to evacuate the building or unit; (4) Type of drill (i.e., obstructed or unobstructed); (5) Record of problems encountered and steps taken to rectify them; (6) Employee observation of each resident's ability to carry out evacuation procedures. 4. Residents shall be instructed in all alternative methods of escape since the primary	S 705		

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S 705	Continued From page 24 exit may be unusable due to fire and/or smoke. Such instruction shall be documented in the record described in § 2.4.30{l)(3)(a) of this Part. 5. Each new resident shall be oriented to the fire drill procedure on admission, with documentation of the orientation placed in the resident's record. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to conduct drills simulating fire emergencies, testing the effectiveness of the fire evacuation plan, were conducted at least six (6) times per year on a bimonthly basis, as defined in Fire Safety Code-General Provisions **(R.1.** Gen. Laws Chapter 23-28.1). Findings are as follows: Record review of the residence's fire drill binder failed to reveal evidence of bimonthly fire drills from January 2022 though January 2023. During an interview on 9/26/2023 at approximately 12:42 PM, the Administrator could not provide evidence of fire drills being conducted from January 2022-January 2023, as required.	S 705		
S 730	Practices and Procedures, Violations, Sa 2.4.32.B Variance Procedure 2.4.31 (B) Variance Procedure B. A request for a variance shall be filed by a high managerial agent of the assisted living residence in writing, and must set forth in detail the basis	S 730		

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s 730	Continued From page 25 upon which the request is made including: 1. Identification of the specific regulatory section(s) herein; 2. Alternative actions, processes, or procedures that through the facility's implementation will facilitate compliance with the specific regulatory intent, and how the Residence will ensure staff awareness and training regarding the variance, when appropriate. 3. A variance period shall not exceed the assisted living residence's license period. An assisted living residence must request renewal of the variance when it submits its annual license renewal application. 4. Upon the filing of each request for variance with the Department, and within a reasonable time thereafter, the Department shall notify the applicant by certified mail of its approval or in the case of a denial, a hearing date, time and place may be scheduled if the residence appeals the denial and held in accordance with the provisions of§ 2.4.33 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 obtain a variance for approval from the Department for 3 of 4 sample residents receiving hospice services, Resident ID #s 4, 5, and 6. Finding are as follows: Per the Rules and Regulations for Licensing	S 730		

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S 730	Continued From page 26 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 needing medical or skilled nursing care, including daily professional observation and evaluation, as provided in a health care facility, and/or persons who are bedbound or in need of the assistance of more than one (1) person for ambulation is not appropriate to reside in assisted living residences. However, 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. Furthermore, a new resident may receive daily therapy services and/or limited skilled nursing 'care services, as defined through these Regulations, from a Rhode Island 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..." Record review of the list of residents receiving hospice services provided by the Director of Wellness on 9/26/2023 revealed Resident ID #s 4, 5, and 6 are receiving hospice services. 1. Record review revealed Resident ID #4 moved	S 730		

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S 730	Continued From page 27 into the residence in October of 2022 with a diagnosis of Alzheimer's disease. Record review revealed the resident was admitted to hospice services on 7/29/2023. 2. Record review revealed Resident ID #5 moved into the residence in April 2023 with a diagnosis of dementia. Record review revealed the resident was admitted to hospice services on 6/9/2023. 3. Record review revealed Resident ID #6 moved into the residence in December of 2020 with a diagnosis of dementia. Record review revealed the resident was admitted to hospice services on 12/12/2022. Review of Residents ID #s 4, 5, and 6 records failed to reveal evidence of an approved variance was obtained from the Department, as required. During a surveyor interview on 9/26/2023 at approximately 10:25 AM with the Director of Wellness, she acknowledged the above-mentioned residents are receiving hospice services. Additionally, she acknowledged an approval was not obtained from the Department, as required.	S 730	S730 **Completed 10/14/2023** A full record audit of all resident records was completed. Waiver requests for the 4 memory care residents on Hospice was completed. The RCD is responsible for assuring future compliance.	
S 915	Limited Health Services License Require 2.6.2.M Specific Requirements 2.6.2 **(M)** Specific Requirements **M.** Assisted living residences licensed to provide limited health services are required to have a	S 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01426	A BUILDING: _____ SWING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PHYLLIS SIPERSTEIN TAMARISKALR	3 SHALOM DRIVE 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)	(XS) COMPLETE DATE
s 915	Continued From page 28 licensed physician, a certified nurse practitioner or a licensed physician assistant as a member of the Quality Improvement Committee as defined in § 2.4.3 of this Part. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined the residence, which is licensed to provide limited health services, failed to have a licensed physician, a certified nurse practitioner, or a licensed physician assistant as a member of the Quality Improvement Committee. Findings are as follows: Record review of the residence's Quality Improvement Plan updated in March of 2023 failed to reveal a licensed physician, a certified nurse practitioner or a licensed physician assistant is included on the committee, as required. Additional record review of the attendance for meetings from January 9, 2022, through July 27, 2023, failed to reveal a licensed physician, a certified nurse practitioner or a licensed physician assistant in attendance. During an interview on 9/27/2023 at approximately 9:23 AM, the Administrator acknowledged a licensed physician, a certified nurse practitioner or a licensed physician assistant were not in attendance.	S 915	S915 The facility will have an MD or NP participate in future QAPI meetings going forward. We are negotiating with [redacted] hospice NP to sit on the committee. The ED is Responsible to assure that an MD or NP Is present for all quarterly QAPI meetings.	11/30//2023
s 925	Limited Health Services License Require 2.6.2.0 Specific Requirements	s 925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICAT1ON NUMBER:	(X2) MULTIPLE CONSTRUCTION·	(X3) DATE SURVEY COMPLETED
	ALR01426	A. BUILDING: _____ B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CIIY, STATE, ZIP CODE
THE PHYLLIS SIPERSTEIN TAMARISK ALR	3 SHALOM DRIVE WARWICK, RI 02886

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s 925	Continued From page 29 2.6.2 (0) Specific Requirements 0. Evidence of Pre-employment and Ongoing Health Screening Upon hire and prior to delivering services, employment health screenings shall be required for each individual who has or may have direct contact with a resident receiving limited health services. Such health screening shall be conducted in accordance with the rules and regulations pertaining to Immunization, Testing, and Health Screening for Health Care Workers (Part 20-15-7 of this Title}. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined that the residence failed to obtain proper employment health screenings prior to delivering service for each individual who has or may have direct contact with a resident receiving limited health services for four of seven sample staff reviewed, Staff A, C, I, and H. Findings are as follows: Per the Rules and Regulations Pertaining to Immunization, Testing, and Health Screening for Health Care Workers [216-RICR-20-18-7] it states in part, "...any individual who has or may have direct contact with a resident receiving limited health services must have upon hire or prior to delivering service a review of health records, pertinent laboratory results, and other documentation of a health care worker performed by a licensed practitioner is required in order to determine that the health care worker is free of the communicable diseases cited in these	S 925	S925 All current nursing care staff have been asked to supply a copy of their immunization history or the results of pertinent lab results by the end of the year. Any new staff will be required to supply adequate documentation prior to actually starting to work. The ED and JCS HR representative are responsible to assure compliance. 10/27/23	12/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01426	A. BUILDING: _____ B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 925	Continued From page 30 Regulations, and is also appropriately immunized, tested, and counseled prior to employment." 1. Record review for Staff A revealed a hire date of 1/5/2023. This employee was hired as a Registered Nurse. The record failed to reveal evidence that the employee received screenings for Measles Mumps Rubella (MMR), Varicella, Tetanus, Diphtheria and Pertussis (TDAP), Tuberculosis (TB), and Hepatitis B (Hep B), as required. 2. Record review for Staff C revealed a hire date of 6/28/2020. This employee was hired as a Certified Nursing Assistant (CNA). The record failed to reveal evidence that the employee received screenings, for MMR, Varicella, TDAP, TB, and Hep B, as required. 3. Record review for Staff I revealed a hire date of 6/6/2020. This employee was hired as a CNA. The record failed to reveal evidence that the employee received screenings for MMR, Varicella, TDAP, TB, and Hep B, as required. 4. Record review for Staff H revealed a hire date of 2/8/2016. This employee was hired as a CNA. The record failed to reveal evidence that the employee received screenings for MMR, Varicella, TDAP, TB, and Hep B, as required. During an interview on 9/27/2023 at approximately 1:37 PM, the Administrator could not provide evidence that the required health screenings were conducted as required for Staff A, C, I, and H.	S 925		

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S 003	Initial Comments An unannounced complaint/incident investigation suivey and a biennial State licensure suivey (PYGU11, 07/27/2023) were conducted at this residence. Deficiencies were identified relative to the State licensure suivey.	S 003		

Facthtles Regulation

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