RI Deoartment of Health

STATEMENT OF DEFICIENCIES AND PIAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01426	A. BUILDING: _____ B. WING	C 12/27/2024

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

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S 003	Initial Comments An unannounced complaint/incident investigation survey, ACTS reference numbers 98425, 98836, and 98851, was conducted at this residence on 12/27/2024 to determine compliance with state regulations. Deficiencies were identified.	S 003		
s 160	Organization And Management 2.4.12.C(4-5) Administrative Management 2.4.12 Administrative Management (C)(4) 4. Establishment of written policies and procedures governing the operation of the residence which are aimed, to the extent possible, at maintaining the independence of residents. Such policies shall include provisions to implement no less than the following: a. The appropriate provisions of§ 2.4.18 of this Part and other applicable provisions pertaining to admission, transfer, discharge, visitation privileges, availability and utilization of community resources, leisure time and such other; b. Accountability of the residence when acting as a fiduciary agent for the resident pursuant to § 2.4.18 of this Part; c. Notification of next of kin or other responsible person designated by the resident in the event of illness, accident or death; and d. Such other provisions as may be deemed appropriate. 5. Compliance with all requirements appropriate to the service level for which the residence is licensed.	s 160		

Received
JAN 21 2025
Facilities Regulation

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

1/17/25

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S 160	Continued From page 1 This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined the residence failed to establish written policies and procedures relative to transferring residents to a higher level of care when a change of condition occurs for 2 of 4 residents reviewed, ID #s 1 and 2. Findings are as follows: 1) Resident ID #1 was admitted to the residence in July of 2024. Record review of Resident ID #1's "RT Tasks" note, dated 12/16/2024, revealed the following, "BP (blood pressure) check at 4:30 PM 84/40, advised to drink more fluids, try to eat as [his/her] intake has been limited due to poor appetite...rechecked BP about 8:10 PM 74/40, instructed resident to try to eat something salty, also continue with fluids...called and spoke with Doctor, who would prefer resident to go to ER (Emergency Room) for evaluation due to very low BP, however [they] are declining to go. PCP (Primary Care Provider) spoke with the resident on the phone...[he/she] was advised again to go to the ER for evaluation, but still refused..." Record review failed to reveal a policy regarding resident refusals of transfer for emergency medical treatment. Of note, the resident was found deceased in his/her apartment on 12/17/2024. 2) Resident ID #2 was admitted to the memory care facility in April of 2024 with a diagnosis of mild dementia.	S 160	S160 Resident # 1 - A policy has been created to address Managing an acute change of condition/incident regarding the need for emergency services. Noting the procedure for when a resident refuses to go to the ER. The policy has been reviewed with all staff and all current Assisted Living residents and Memory Care responsible parties. To prevent any future issue an addendum has been added to the Resident handbook outlining the policy. All incidents will be reviewed on the next business day following the incident. All will be reviewed quarterly by the QA safe patient handling committee. See attachment #1 Staff Training sign off. #2 Managing Acute of Change Condition Policy S160 Resident #2 The facility updated the fall policy to specifically include an additional process for memory care residents as follows: **Additional process for memory care residents:** 1. If a memory care resident can communicate regarding the fall and any effects of the fall the regular above fall policy is implemented. 2. If a memory care resident is unable to verbally communicate regarding the fall and any effects of the fall, an RN will assess non-verbal communication:	1/16/2025

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S 160	Continued From page 2 According to the National Palliative and Hospice Institute, "**Mild** dementia (F01.A-, F02.A-, F03.A-] Clearly evident functional impact on daily life, affecting mainly instrumental activities. No longer fully independent/requires occasional assistance with daily life activities." Record review revealed the resident had an unwitnessed fall on 12/10/2024 and was assisted by a staff member who failed to report the incident or have the resident assessed appropriately. This resident had multiple pelvic fractures; however, did not receive medical treatment until 12/17/2024. Record review failed to reveal a facility policy on falls on the memory care unit, where residents are often unable to verbalize what occurred. During an interview on 12/27/2024 at approximately 4:00 **PM,** the Director of Wellness revealed that on 12/17/2024 the facility was notified by Resident ID #2's primary care office that an X-ray revealed multiple fractures of his/her pelvis. Upon knowledge of this, the Director of Wellness began asking staff how this injury could have occurred. At that time Staff A revealed the resident had an unwitnessed fall on 12/10/2024, which was not documented. During the interview the Director of Wellness and Administrator acknowledged the facility does not have a policy specific to falls on the memory care unit.	S 160	S160 continued from previous page 2 Resident #2 continued a. Does the resident appear in distress, b. Is the resident expressing pain physically via facial grimacing, protecting or favoring any body part, exhibiting any inability to move. c. Vital Signs are out of normal range d. After assessment the above fall policy is implemented. 3. If an RN is unavailable to assess a memory care resident following an unwitnessed fall, staff should call 9-1-1 for assessment by EMS All staff have been retrained on the updated fall policy. All falls for the last quarter were reviewed at the 12/30/24 QA and Safe Resident handling meeting. The CMT in question received additional individual training on reporting and incident reporting. We are implementing an additional written shift to shift report that requires all staff initial upon review. The report includes any incidents. unusual events or no change in status. For one month the senior leadership will review the shift-to-shift report weekly and initial their review, then monthly for 3 months and then quarterly. See attachment #3 Fall policy #4 QA Incident Review #1 Training Sheets	
S 230	Organization And Management 2.4.13.A Management Of Services 2.4.13 (A/B) Management of Services	S 230		

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S 230	Continued From page 3 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 all care and services in accordance with the prevailing community standard of care relative to monitoring blood pressure for one of four sample residents, Resident ID #1. Findings are as follows: According to Clinical Nursing Skills, Fifth Edition, 2000, if any unusual findings are assessed, complete a more in-depth assessment of the particular system affected. Throughout the day, continue to assess changes in the client's condition by paying particular attention to the alterations from normal that you identified in the original assessment. At the end of the shift, make a notation of any changes in the client's condition, Record review of Resident ID #1's "RT Tasks" note, dated 12/16/2024, revealed the following, "BP (Blood pressure) check at 4:30 PM 84/40, advised to drink more fluids, try to eat as [his/her]	S230	S230 We have initiated a new Management of change of condition/incident policy as noted in response to S160. We have also instituted a double check process for follow up when there is a change in condition/incident. Based on the new policy the resident/family or responsible party would need to agree to an immediate additional support plan. In addition to the above we have implemented the following: 1. Tamarisk staff will assign additional checks as a service update in the EMR and assign the checks as a task to individuals for at least the next 24 hours. 2. We have reinstated a paper shift report that every resident is reviewed, and the task as noted above will be reviewed for completion. Each Staff member will review the paper report and sign that they have reviewed it before the beginning of each shift. Shift report compliance will be reviewed daily by the MOD. 3. All staff will be trained in the new system and sign off that they understand the process.	1/16/2025

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S 230	Continued From page 4 intake has been limited due to poor appetite...rechecked BP about 8:10 PM 74/40, instructed resident to try to eat something salty, also continue with fluids...called and spoke with Doctor, who would prefer resident to go to ER (Emergency Room) for evaluation due to very low BP, however [they] are declining to go. PCP (Primary Care Provider) spoke with the resident on the phone...he/she was advised again to go to the ER for evaluation, but still refused...Doctor states may check BP in AM prior to taking Carvedilol (blood pressure medication). Added service for BP check in AM. Staff will check on resident again this evening." Record review failed to reveal a check on the resident in the evening after 8:10 PM. Further record review failed to reveal any assessment of the resident after the conversation with the resident's PCP in the evening on 12/16/2024. Record review of a "RT Tasks" note, dated 12/17/2024, revealed the resident's son, due to being unable to reach the resident, requested a wellness check. "I text him back at 12:15 PM from the elevator, Hi checking on them now...Upon entering the apartment [the Resident] was lying on [his/her] back in bed. No respirations, no pulse. Extremities cold and cyanotic." During an interview on 12/27/2024 at approximately 4:30 PM, the Director. of Wellness and Administrator acknowledged that the facility failed to re-assess Resident ID #1.	S230	S230 continued from previous page 4 For one month the senior leadership will review the shift-to-shift report weekly and initial their review, then monthly for 3 months and then quarterly at the QA meeting. See attachment #1 Training sign off #5 Sample shift report	
S 360	Residency Requirements 2.4.16.C Resident AssessmenVService Plans	S 360		

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S 360	Continued From page 5 2.4.16 (C) Resident Assessments and Service Plans C. The Department-approved assessment form, or such other assessment form as approved by the Department, shall be utilized in completing the assessment on each resident who is admitted to the residence. (Approved Department form is available for downloading online at http://health.ri.gov/forms/assessment/AssistedLivingResident.pdf). 1. Assisted living residences not intending to use the Department's assessment form shall submit their proposed assessment forms with a cover letter of intent to the Center for Health Facilities Regulation as specified in § 2.4.6(A) of this Part. 2. All assessment forms shall report information appropriate to determine compatibility and compliance with the residency criteria, and shall indicate that the resident's needs can be met by the assisted living residence within its licensure level, and shall gather information appropriate for the development of an individualized service plan. a. The assessment form shall be designed to demonstrate compliance with the assisted living residence's criteria for residency. b. The assessment form shall also be designed to demonstrate that the assisted living residence can meet the resident's needs and preferences. 3. The assessment form shall also be designed to provide information appropriate for	S 360	S360 We have requested a variance for the use of the Residex Rtask assessment and care planning forms in lieu of the RI App C. Until such variance is granted, we will continue to use the traditional RI App C form as well. See attached request with supporting documentation clarifying that all of the App C items are also identified in the Rtask assessment. No residents will be affected because any future changes in assessment forms or processes will be reviewed in advance with the DOH for whether any additional variances need to be pursued No future document or process changes will be made without DOH approval. We will monitor the use of both formats until the variance is approved at quarterly QA meetings.	1/16/2025

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s 360	Continued From page 6 the development of an individualized service plan in accordance with§ 2.4.16(G)(1) of this Part. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined the facility failed to use the Department assessment form, or such other assessment form as approved by the Department, in completing the comprehensive assessments on 4 of 4 residents reviewed, ID #s 1, 2, 3, and 4. Findings are as follows: Resident ID #1 was admitted to the facility in July of 2024, record review reveals the initial assessment, dated 07/10/2024, was completed on a facility assessment form, which is not approved by the Department. Further review revealed subsequent assessments dated 07/17/2024, 08/26/2024, and 12/02/2024 on facility assessment forms not approved by the Department. Resident ID #2 was admitted to the facility in September of 2024, record review reveals an initial assessment on the Department assessment form. Further review revealed subsequent assessments dated 12/09/2024 and 12/20/2024 on facility assessment forms not approved by the Department. Resident ID #3 was admitted to the facility in May of 2022, record review revealed assessments on the Department assessment form dated	S 360		

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s 360	Continued From page 7 05/22/2022, 05/23/2023, and 05/20/2024. Further review revealed a subsequent assessment dated 11/07/2024 on a facility assessment form not approved by the Department. Resident ID #4 was admitted to the facility in April of 2024, record review revealed a partially completed initial assessment on the Department assessment form. Further review revealed subsequent assessments dated 07/17/2024, 10/09/2024, and 12/20/2024 on facility assessment forms not approved by the Department. During an interview on 12/27/2024 at approximately 3:00 PM, the Administrator acknowledged the facility assessment forms used to complete the above-mentioned residents' assessments have not been approved by the Department.	s 360		
s 430	Residency Requirements 2.4.17.G Reporting Requirements 2.4.17 (G) Reporting Requirements G. The residence shall maintain evidence that all reportable incidents have been thoroughly investigated and that actions have been taken to prevent further incidents while the investigation is in progress. Appropriate corrective action shall be taken, as necessary. The results of said investigation shall be reported to the Department, within five (5) business days, on forms supplied by the Department. This Requirement is not met as evidenced by:	S430		

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S430	Continued From page 8 Based on record review and staff interview it has been determined the facility staff failed to appropriately report and prevent future incidents for a singular resident reviewed for an unwitnessed fall in the secure memory care unit, 10#2. Findings are as follows: Resident ID #2 was admitted in April of 2024 with a diagnosis of mild dementia. Record review revealed the resident had an unwitnessed fall on 12/10/2024 and was assisted by a staff member who failed to report the incident or have the resident assessed appropriately. Based on the incident report submitted to the Rhode Island Department of Health on 12/19/2024 the resident had an unwitnessed fall in the bathroom in which no injuries were noted at the time. The resident went to his/her primary care facility for a visit on 12/16/2024 where x-rays showed pelvic fractures; the resident was admitted to the hospital on 12/17/2024. Record review of "R Tasks-Incident Report," reveals in part, "...CNA (Certified Nursing Assistant) heard resident call for help and she went and check and she found [her/him] on the floor in the bathroom on [his/her] buttox. She called the CMT (certified medication technician) and she checked [her/him] and found no injuries. They then picked [her/him] up and walk back to bed...Was the facility nurse notified: NO..." The resident was not assessed by a Registered Nurse or other independent practitioner, per scope of practice requirements.	S430	S430 The facility updated the fall policy to specifically include an additional process for memory care residents as follows: **Additional process for memory care residents:** 1. If a memory care resident can communicate regarding the fall and any effects of the fall the regular above fall policy is implemented. 2. If a memory care resident is unable to verbally communicate regarding the fall, and any effects of the fall. An RN will assess non-verbal communication: a. Does the resident appear in distress, b. Is the resident expressing pain physically via facial grimacing, protecting or favoring any body part, exhibiting any inability to move. c. Vital Signs are out of normal range d. After assessment the above fall policy is implemented. 3. If an RN is unavailable to assess a memory care resident following an unwitnessed fall, staff should call 9-1-1 for assessment by EMS All staff have been retrained on the updated fall policy. All falls for the last quarter were reviewed at the 12/30/24 QA and Safe Resident handling meeting.	1/16/2025

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S 430	Continued From page 9 The policy titled "Resident Falls", dated March 2013, states in part, "...After resident has been taken care of, an incident report must be completed and signed by the staff person who witnessed or assisted during the incident, signed by the Resident Care Director/Designee..." During an interview on 12/26/2024 at approximately 4:00 PM, the Director of Wellness revealed that on 12/17/2024 the facility was notified by Resident ID #2's primary care office that an X-ray revealed multiple fractures of his/her pelvis. Upon knowledge of this, the Director of Wellness began asking staff how this injury could have occurred. At that time Staff A revealed the resident had an unwitnessed fall on 12/10/2024, which was not documented. The Director of Wellness and Administrator could not provide evidence the resident was assessed appropriately, the fall was reported timely, and future incidents were prevented from occurring relative to Resident ID #2.	S430	R430 continued from page 9 The CMT in question received additional individual training on reporting and incident reporting. In addition, all staff have received retraining of all types of incidents that require reporting. All incidents are forwarded to the nurse for review the next day. The nurse will follow the policy accordingly. We are implementing an additional written shift to shift report requiring that staff initial upon review. The report includes any incidents, unusual events or no change. For one month the senior leadership will review the shift-to-shift report weekly, then monthly for 3 months and then quarterly. See attachment #3 Fall policy #1 Training Sheets # 6 Incident Policy	