RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01519	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD WOODS	171 PLEASANT VIEW AVENUE SMITHFIELD, RI 02917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 003	Initial Comments An unannounced complaint/incident investigation survey, ACTS reference numbers 100484, 100402, 100303, 100147, 100221, 100222, 99904, 99866, and 99840, was conducted at this residence on 04/22/2025 to determine compliance with state regulations. Deficiencies were identified as a result of this survey.	S 003	The filing of this plan of correction does not constitute an admission of the allegations set forth in this statement of deficiencies. This plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.	5/31/25
S 230	Organization And Management 2.4.13.A Management Of Services 2.4.13 (A/B) Management of Services A. Each residence shall provide services with adequate professional and ancillary employees and in accordance with applicable state law. Further, the residence shall assure that all services are rendered in a safe and effective manner and consistent with the requirements herein. The residence shall provide all care and services to all residents in accordance with the prevailing community standard of care. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to provide care and services in accordance with the prevailing community standard of care relative to administering medications in accordance with written physician's orders for the singular resident reviewed for oxygen, Resident ID #1.	S 230	Received MAY 15 2025 Facilities Regulation 5/16/25	

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ALRA | (X6) DATE: 4/14/2025

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S 230	Continued From page 1 Findings are as follows: Record review of ID #1 revealed he/she was admitted to the residence in September of 2023 with a diagnosis that includes, but is not limited to, chronic obstructive pulmonary disease (COPD). Record review of progress notes dated 4/18/2025 revealed an entry that reads in part, "...CNA (Certified Nursing Assitant) reported to this writer that resident had turned [his/her] O2 (oxygen) NC (nasal cannula) to 4L (liters), Call placed to doctor to confirm O2 orders..." Record review of the resident's physician's orders as of 4/22/2025 failed to reveal that the resident had an active order for oxygen. During a surveyor observation and interview with the resident on 4/22/2025 at 1:15 PM, he/she revealed he/she has been on oxygen for approximately eight years and uses it one to two times a week. During a surveyor interview on 4/22/2025 at approximately 2:30 PM with the Executive Director and the Director of Wellness, they acknowledged the resident did not have an active physician's order for oxygen.	S 230	Resident ID#1 orders updated to reflect accurate oxygen order. Resident ID#1 self-med assessment completed on 4/25/25. In-servicing to be completed with nursing staff on appropriate O2 orders. Housewide audit to be completed by 5/16/25 to ensure all residents utiizing oxygen have an active order WD and/or Designee will audit 100% of residents on 02 weekly x4 weeks then monthly x5 months to ensure all residents on 02 have active order for oxygen. Results of audits will be reviewed in Quarterly QA x2.	
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	S 365		

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S 365	Continued From page 2 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 that the residence failed to review the assessment at intervals not to exceed (12) months and each time a resident's condition changes significantly for the singular resident reviewed for oxygen use, Resident ID# 1. Findings are as follows: Record review of ID #1 revealed he/she was admitted to the residence in September of 2023 with a diagnosis that includes, but is not limited to, chronic obstructive pulmonary disease (COPD). Record review of progress notes dated 4/18/2025 revealed an entry that reads in part, "...CNA(Certified Nursing Assitant) reported to this writer that resident had turned [his/her] O2 (oxygen) NC (nasal cannula) to 4L (liters), Call placed to doctor to confirm O2 orders..." Record review of a document titled, Meridian Eval-RI-V9 dated 2/4/2025, Section M reveals the following: -Resident requires or request administration of medication -Resident is unable to self-administer medications	S 365	Resident ID#1's assessment and service plan were redone on 4/25/25 to accurately reflect independent oxygen use. In-servicing to be completed by 5/16 on correctly identifying oxygen use in assessment and service plans for residents. Education on-going for RNs completing assessments in the community. House wide audit of all residents utilizing oxygen to be completed by 5/16 to ensure oxygen use is captured on assessment and service plan. Create schedule of assessments due by 5/9/25. Contract with RN 40 hrs/week to focus on assessment compliance by 5/31/25.	

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S 365	Continued From page 3 -Resident does not use oxygen During a surveyor observation and interview with the resident on 4/22/2025 at 1:15 PM, he/she revealed he/she has been on oxygen for approximately eight years and uses it one to two times per week. During a surveyor interview on 4/22/2025 at approximately 2:30 PM with the Executive Director and the Director of Wellness, they acknowledged the comprehensive assessment dated 2/4/2025 was completed for a change of condition and it inaccurately reflects the resident's need for oxygen and does not accurately refect the resident is self-administering the oxygen.	S 365	Complete a minimum of 5 assessments per week through 5/31. Complete a minimum of 10 assessments per week thereafter with expected compliance by 6/15. ED and/or Designee will audit 25% of completed to assessments to ensure timely completion weekly x4 weeks then monthly x 5months. Results of audits will be reviewed in Quarterly QA x2.	