PRINTED: 12/13/2023
FORM APPROVED

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01515	A. BUILDING: _____ B. WING _____	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALCYON AT WEST BAY LLC	2783 WEST SHORE ROAD WARWICK, RI 02889

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S 003	Initial Comments An unannounced complaint/incident investigation survey was conducted at this residence. Deficiencies were identified.	S 003		
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 that the residence failed to adhere to the prevailing standard of care for the one sample resident reviewed relative to falls, ID #1. Findings are as follows: According to the National Library of Medicine, "Falls in older adults are a major public health concern often resulting in longstanding pain, functional impairment, disability, premature nursing home admission, increased length of stay in hospitals, and mortality." The residence's fall policy provided by the Director of Wellness states in part, "...when any	S 230	1. Will provide in-service to staff on the policy related to Falls. To include assessment post fall, notifications, ongoing assessment post fall, when to send to ER, fall risk assessments, DOH reporting, completion of incident reports and documentation. Please find attached meeting agenda for Care Staff Meeting. 2. Completed audit of incident reports in last 30 days to ensure that we have appropriately acted and the residents are having no residual issues. Please find attached audit tool. 3. a. RN to complete Fall Risk Assessment upon admission and quarterly thereafter. (form attached) b. Survey residents' rooms to determine: c. Clear pathways to bathroom and bedroom doors. d. Resident has call pendant on or within reach. e. Adequate lighting in apartment. 4. DON to review ALL incidents within 24 hours for completion and appropriateness of assessment and interventions and document in EMR. 5. RN to assess every fall within 24 hours of fall and document assessment in notes. 6. All findings and deficiencies to continue to be brought to QAPI. Date of Compliance: January 17, 2023	1/4/24

Facilities Regulation

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

Melissa Stock — Executive Director — 1/3/24

Emailed on 12/29/23

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S 230	Continued From page 1 resident experiences a fall, the facility will: assess the resident and complete a post fall assessment...document all assessments and actions..." Record review revealed ID #1 was admitted to the special care unit in April of 2021 with diagnoses including, but not limited to: dementia and osteopenia. Record review of a complaint that was sent to the Department of Health on 11/22/2023 alleges in part, "...On 10/22/2023 my [parent] had fallen. The nursing staff responded and asked, 'did you hit your head' My [parent] is 89 years old and replied no, there was no further follow up." Record review of an Assisted Living 5-day Investigation report dated 10/30/2023 reveals: "...Resident self reported to [his/her] family that [s/he] had slid from [his/her] recliner a few days earlier. Family reported this to nursing. Nurse assessed and noted some echimosis (sic) to mid back. [S/he] also reported some pain. Acetaminophen administered. On 10/23/2023 POA (power of attorney) requested resident be sent to the ER (emergency room) for further evaluation and treatment. Resident was diagnosed at hospital with rib fracture and hypoxia. Admitted to hospital..." Record review failed to reveal a documented nursing assessment was completed post-fall, as required by the residence's policy. Initial note written by Staff A, Registered Nurse, dated 10/22/2023 reveals the following, "...It was reported today that yesterday this resident slid out of [her/his] chair. Today [s/he] is now complaining of mid back pain and has a mid-back bruise. I contacted the family to get and deliver the 325mg	S 230		

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S 230	Continued From page 2 Acetaminophen that [s/he] has a PRN [as needed prescription] for." During an interview on 12/5/2023 at approximately 12:10 PM, the Administrator acknowledged ID #1 did not have a documented nursing assessment after the fall, per facility policy.	S 230		
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 that the residence failed to report an accident, incident, or medication error resulting in a hospital admission by the end of the next working day for one sample resident reviewed relative to falls, ID # 1. Findings are as follows: Record review revealed ID #1 was admitted to the special care unit in April of 2021 with	S 405	1. Please find the above stated in-service to implement this training for Reporting Requirements. 2. Completed review/audit of all incidents in the last 30 days to ensure that incidents that should have been reported were. Please see attached audit tool. 3. Completed audit of all transfers to the hospital for reasons and if should have been reported to ensure proper reporting took place. Please see attached all audit forms documentation of deficiencies and corrections. 4. Plan going forward to include: · DON will continue to be contacted in real time regarding ANY transfers to the hospital. · DON or Designee to follow up with hospital regarding treatment and admission status. · DON or Designee to report all accidents, incidents, and medication errors resulting in out-of-residence emergency medical services resulting in a hospital admission to the Center for Health Facilities Regulation in writing by the end of the next working day. A 5-Day report will follow.	

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S 405	Continued From page 3 diagnoses including, but not limited to: dementia and osteopenia. Review of the "Assisted Living Residence Required Incident Reporting" form dated 10/30/2023 indicates ID #1 had an unwitnessed fall on 10/22/2023 which resulted in back pain. Review of the "Assisted Living Residence - Five (5) Day Investigation Report" form also dated 10/30/2023 states in part, "...Date the incident/allegation occurred 10/22/2023. Date the incident/allegation was initially reported to the Department: 10/30/2023...On 10/23/2023 POA (power of attorney) requested resident be sent to the ER (emergency room) for further evaluation and treatment. Resident was diagnosed at hospital with rib fracture and hypoxia. Admitted to hospital then transferred to ST (short-term) rehab..." Record review of a complaint that was sent to the Department of Health on 11/22/2023 alleges in part, "...On 10/22/2023 my [parent] had fallen. The nursing staff responded and asked, 'did you hit your head ...My [parent] is 89 years old and replied no, there was no further follow up." Record review failed to reveal the residence reported the fall resulting in hospital admission by the end of the next working day, as required. During an interview on 12/5/2023 at approximately 12:15 PM, the Administrator acknowledged the above-mentioned incident was not reported to the Department within the required timeframe.	S 405	5. Please see attached communication log currently being utilized to maintain current standings of residents out due to hospitalization/MLOA. 6. All deficiencies and findings to be discussed at QAPI ongoing. Date of Compliance: January 17, 2023	

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S 565	Continued From page 4	S 565		
S 565	Residential Care Services 2.4.24.B.1 Medication Services 2.4.24 (B) (1) Administration of Medications 1. Residences licensed at the M1 level may administer medications to residents including, but not limited to, removing medication containers from storage, assisting with the removal of a medication from a container for residents with disability which prevents independence in this act, and/or administering the medication directly to the resident. a. The resident or guardian must provide written authorization for the residence to provide administration of medications. b. Medications shall be administered in accordance with written orders of a physician. The residence must provide in writing, a description of services provided by the residence to each physician, including limitations on service. c. All medications must be checked against a physician's orders by a licensed nurse, or pharmacist. d. The resident must be identified prior to administration of any medication. e. The medication must be in the original pharmacy-dispensed container with proper label and directions attached and be administered in accordance with such label. f. Injectable medications, including but not limited to insulin, which cannot be self-administered by the resident, must be	S 565	1. Education/Inservice will be provided to nurses and CMTs regarding proper medication administration; to include medication administration policy. Please find the attached meeting agenda. 2. DON to complete Med Cart Audit immediately and then weekly ongoing by a nurse. Please find the attached med cart audit. 3. DON or nurse designee will complete unannounced audits on med passes on all three shifts ongoing for next 14 days to ensure medication compliance and then weekly, thereafter, until all med passes are completed with zero errors and all staff are fully trained on expectations. Please find the attached audit form to be utilized for evaluation of each CMT. 4. Medication Ordering Policy – in place. Please see attached policy. 5. All findings will be discussed at QAPI. Date of Completion: January 17, 2023	

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S 565	Continued From page 5 administered by a licensed nurse. g. There shall be written a policy/procedure for the disposal of hypodermic needles, syringes and other such instruments that is in compliance with rules and regulations governing Hypodermic Needles, Syringes & Other Such Instruments (Part 20-15-6 of this Title). (1) The legal destruction of hypodermic needles, syringes or other such instruments is the responsibility of the last entitled or authorized possessor. (AA) All personnel or residents legally authorized to use disposal syringes and needles, shall destroy them after one (1) use. (BB) Excess and undesired needles, syringes and other such instruments shall be stored in impervious, rigid, puncture- resistant container for disposal. Intact needles shall be placed directly into the collection containers. (CC) Personnel handling disposal waste materials such as needles, syringes, and other such instruments may treat and destroy such waste by a DEM-approved alternative treatment/destruction technology or prepare the regulated medical waste for off-site transport by a DEM-permitted medical waste transporter. h. Individual medication records must be retained for each resident to whom medications are being administered and each dose administered to the resident must be properly recorded. i. Any medication administered by the	S 565		

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S 565	Continued From page 6 residence and refused by a resident shall be documented and reported, as appropriate. j. Medications shall be stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access. Provisions for safe storage may include lockable containers, secure spaces, or lockable units, as appropriate to the residence and the resident population. k. All medication in the residence, regardless of whether controlled by employees or by the resident, shall be stored securely as stated in § 2.4.24(A)(3)(a)(8) of this Part. l. All centrally stored medications shall be maintained in accordance with manufacturer's labeling and administered by authorized personnel. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to ensure medications were stored in a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access for two of two resident's reviewed ID #s 1 and 2. Findings are as follows: 1) Record review revealed ID #1 was admitted to the special care unit in April of 2021 with diagnoses including, but not limited to: dementia and osteopenia. Record review of ID #1's active physician's orders revealed "Acetaminophen Tab 325mg, 2 tabs by mouth every 4 hours as needed for pain or fever"	S 565		

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S 565	Continued From page 7 dated 01/22/2022. Review of a note written by Staff A, Registered Nurse, dated 10/22/2023 reveals the following, "...It was reported today that yesterday this resident slid out of [her/his] chair. Today [s/he] is now complaining of mid back pain and has a mid-back bruise. I contacted the family to get and deliver the 325mg Acetaminophen that [s/he] has a PRN [as needed prescription] for." Record review of an Assisted Living 5-day Investigation report dated 10/30/2023 reveals: "...Resident self reported to [his/her] family that [s/he] had slid from [his/her] recliner a few days earlier. Family reported this to nursing. Nurse assessed and noted some echimosis (sic) to mid back. [S/he] also reported some pain. Acetaminophen administered. On 10/23/2023 POA (power of attorney) requested resident be sent to the ER (emergency room) for further evaluation and treatment. Resident was diagnosed at hospital with rib fracture and hypoxia. Admitted to hospital..." Record review failed to reveal the medication the resident required for pain was available for administration as ordered. 2) Record review revealed ID #2 was admitted to the special care unit in May of 2023 with a diagnosis of dementia. Record review of a complaint submitted to the Department of Health in November of 2023 alleges that Resident ID #2's family was visiting when Staff B, Certified Medication Technician, delivered an ice cream to the resident and reported to the family member that medication was in it. Over 30 minutes later the ice-cream had	S 565		

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S 565	Continued From page 8 melted, and the resident's family member went to tell the staff the ice cream had not been eaten. Staff B then allegedly indicated the ice cream had the resident's melatonin in it. Record review of ID #2's service plan dated 9/10/2023 reveals, "Staff to store and administer medication. Please crush medication and put in ice cream or coffee to increase medication compliance." Record review of ID #2's medication list reveals an order for "Melatonin tab 5MG by mouth daily at bedtime." During an interview on 12/5/2023 at approximately 12:10 PM, the Administrator acknowledged that the documentation indicates ID #1's as needed pain medication was not available when needed, and ID #2's medication was left unattended by staff with the resident.	S 565		