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 07/22/2024

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

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S 003	Initial Comments An unannounced complaint/incident investigation survey was conducted at this residence. No deficiencies were identified.	S 003	The filing of this plan of correction does not constitute an admission of the allegations set for in this statement of deficiency. This plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.	9/30/24
S 150	Organization And Management 2.4.12.A Administrative Management 2.4.12 (A) Administrative Management A. All licensees shall provide staffing which is sufficient to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being of the residents, according to the appropriate level of licensing. At least one (1) staff person who has completed employee training as outlined in § 2.4.12(G) of this Part shall be on the premises at all times. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined the facility failed to provide staffing which is sufficient to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the residents, according to the appropriate level of licensing. Findings are as follows: Record review of a facility submitted Assisted Living Residence Required Incident reporting form dated 7/12/2024 revealed the following, "It was discovered that [Staff A's, Certified Medication Technician] license has been expired since 6/30/24. She was sent home from her shift and has been taken off the schedule ... She has worked the following dates: July 1, 4, 5, 6, 7, 8, &	S 150	1. Staff A and B completed the necessary paperwork to get license reinstated. Staff A was terminated due to administering medications outside of PCP orders and did not return to work. Staff B returned to work on 7/19/24. 2. A house wide audit of all current staff members to ensure license is active was completed on 7/12/24. 3. BOM and/or Designee will keep a binder with a copy of all staff licenses. Binder will be audited in February and May to identify any staff members with a license renewal due in March or June. 4. ED and/or Designee will audit 10%of employees to ensure an active license weekly x 4 weeks then monthly x 5 months. Results will be reviewed in Quarterly QA x 6 months to ensure compliance. RECEIVED AUG 21 2024 FACILITIES REGULATION	

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ALRA — (X6) DATE: 8/20/24

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S 150	Continued From page 1 11." Record review of a facility submitted Assisted Living Residence Required Incident reporting form dated 7/12/2024 revealed the following, "It was discovered that [Staff B's, Certified Nursing Assistant] license has been expired since 6/30/24. She was sent home from her shift and has been taken off the schedule ... She has worked the following dates: July 2, 5, 9 and 12." Review of facility policy and procedures failed to reveal a system in place to verify working employees continue to have active licenses. During an interview with the Administrator on 7/16/2024 at approximately 1:00 PM, she acknowledged that Staff A and B were working without active licenses.	S 150		
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	S 230	1. Staff member A that was identified as giving medications outside scheduled time was terminated on 7/17/24 following completion of investigation. 2. No adverse effects were noted for the residents that received their medications outside the scheduled time. 3. Education to be completed with Nurses and Medication Aides on the five guidelines to ensure safe drug administration. To be completed by 9/7/24 4. Education to be completed with Nurses and Medication Aides on following physician 's orders and the allowed grace period of 1 hour before and 1 hour after scheduled medication time. To be completed by 9/7/24	

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S 230	Continued From page 2 been determined the residence failed to ensure that all services are rendered in a safe and effective manner and to provide all care and services to all residents in accordance with the prevailing community standard of care relative to medication for 33 residents residing on the secure memory care unit, Resident ID #s 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, and 34. Findings are as follows: 1) According to Basic Nursing, Mosby, 3rd, "the five guidelines to ensure safe drug administration include the right drug, the right dose, the right clients, the right route and the right time." 2) According to the Institute for Safe Medication Practices, "Medications administered more frequently than daily but not more frequently than every 4 hours (e.g., BID, TID, q4h, q6h) Administer these medications within 1 hour before or after the scheduled time." During an interview on 7/16/2024 at approximately 10:00, the Administrator revealed that during a 5-day investigation period regarding Staff A, Certified Medication Technician, the facility discovered the associate was administering and signing off on medications to be administered at 8:00 PM between the hours of 5:00 and 6:00 PM. Record review of "Med Pass Detail" sheets dated 6/1/2024-7/12/2024 revealed that Staff A administered nighttime medications, medications ordered for 8:00 PM, between the hours of 5:00 and 6:00 PM to 29 residents.	S 230	5. RN and /or Designee will audit 10% of resident's administered medications to ensure they were administered within the allowed time frame. Audits will be completed weekly x4 weeks then monthly x 5 months. Results of audits will be reviewed in Quarterly QA x 6 months to ensure compliance. 6. RN and/or Designee will audit 15% of resident's physician's orders to ensure all medications are available in medication cart weekly x4 weeks then monthly x 5 months. Results will be reviewed in Quarterly QA x 6 months to ensure compliance.	

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S 230	Continued From page 3 During an interview with the Administrator on 7/16/2024 at approximately 2:00 PM, she acknowledged that Staff A did not administer medications as ordered. 3) Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients." -Record review of Resident #2's medication orders revealed: "Loperamide HCL 2 MG Capsules, Take one tab PO (by mouth) at HS (hours of sleep)" "Furosemide 20 MG Tabs, Give one tab PO every other day." Observation of the facility's secure unit medication cart on 7/16/2024 from 11:30 AM-1:00 PM failed to reveal the above-mentioned medications were available. -Record review of Resident #3's medication orders revealed: "ELIQUIS 2.5MG TABLET 2.5MG TAB TAKE 1 TAB BY MOUTH TWO TIMES DAILY Schedule: DAILY AT 08:00, DAILY AT 20:00." "ONDANSETRON HCL F/C 4MG TABLET 4MG TAB TAKE 1 TAB BY MOUTH EVERY 6 HOURS AS NEEDED NAUSEA" "SENNA 8.6MG TABLET 8.6MG TAB TAKE 2 TABS BY MOUTH DAILY AS NEEDED CONSTIPATION"	S 230		

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S 230	Continued From page 4 "SODIUM CHLORIDE 0.65% GIVE 2 SPRAYS BOTH NOSTRILS EVERY 6 HOURS AS NEEDED FOR DRYNESS" Observation of facility's secure unit medication cart on 7/16/2024 from 11:30 AM-1:00 PM failed to reveal the above-mentioned medications were available. -Record review of Resident #4's medication orders revealed: "Acetaminophen 500 MG tablets take one by mouth for pain" Observation of facility's secure unit medication cart on 7/16/2024 from 11:30 AM-1:00 PM failed to reveal the above-mentioned medication was available. During interviews on 7/16/2024, 7/19/2024, and 7/22/2024 the Administrator and Director of Wellness acknowledged that the above-mentioned medications had active physician's orders; however, were not available for the three residents reviewed for medication availability.	S 230		
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.	S 365		

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S 365	Continued From page 5 This Requirement is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined the residence failed to update the comprehensive assessment each time a resident's condition changed significantly for the singular resident reviewed relative to a change in condition, Resident ID #1. Findings are as follows: Record review of Resident ID #1 revealed he/she was admitted to the residence on 9/25/2023 with a diagnosis including, but not limited to, Alzheimer's. Record review revealed Resident ID #1 exposed themselves to another resident on 6/5/2024. Review of a 5-day investigation report regarding this incident revealed, "facility working on discharge for [resident]." Record review revealed an additional incident on 6/25/2024; Resident ID #1 was found walking down the road hitch-hiking. Upon return to the residence instructions from management were for him/her to spend the weekend in memory care for safety, which resulted in the resident becoming combative and ultimately agreeing to an assessment at the hospital. Record review revealed that on 6/28/2024 the resident returned from the hospital with no new orders. The facility indicated to the resident and family, in order to remain in the facility, the resident needed to go to the secure memory care unit or the family needed to provide a 1:1. Record review revealed the resident was	S 365	1. Resident #1 has since been discharged from the community. 2. House wide audit of all resident assessments was completed on 8/6/24 to identify whether a 90-day nurse review or comprehensive assessment is due and the date that it is due. Compliance to be obtained by 9/30/24. 3. House wide audit of all service plans completed on 8/20/24 to ensure a current service plan in place. Compliance to be obtained by 9/30/24. 4. Education to be completed with nursing staff by 8/30/24 on recognizing when a COC needs to be completed for a resident needing a higher level of care. 5. Meridian has added the 90-Day Nurse Review in PCC to ensure accuracy and the information on assessment aligns with the RI regulation and is currently being utilized by the community. 6. Weekly risk meeting to be held with ED and RN to ensure any resident with a COC is identified and addressed timely. Starting week of 8/19/24. 7. ED and/or Designee will audit 10% of resident assessments/service plans and 100% of resident's assessments/service plans that have been identified as a COC to ensure assessment and service plan are accurate and reflect care being provided. Audits will be completed weekly x4 weeks, then monthly x5 months. Results of audits will be reviewed in Quarterly QA x 6 months to ensure compliance.	

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S 365	Continued From page 6 assessed at the hospital and returned to the traditional assisted living community on 7/1/2024. Record review revealed on 7/2/2024 another incident of Resident ID #1 exposing themselves to other residents was reported. He/she was sent out to the hospital again and will not be allowed to return to the facility. Record review of the resident's comprehensive assessment dated 4/25/2024 failed to reveal the above changes in condition relative to behaviors and unit placement. During a surveyor interview on 7/16/2024 at approximately 2:00 PM, the Administrator acknowledged the resident experienced changes in condition and the assessment failed to be updated, as required.	S 365		
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	S 565		

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S 565	Continued From page 7 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 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,	S 565	1. Resident ID #2 had a medication reconciliation completed on 7/12/24 by previous WD. 2. Additional nursing resources were brought in to complete an audit of all medication carts to ensure medications were available per physician's orders. All meds without an active order or expired were removed from the carts, logged, and disposed of. Audit completed on 7/19/24. 3. Nurse Consultant from Four Winds Senior Care started on 7/23/24 to assist in overseeing medication management, provide education, observe medication aides and other tasks as assigned. 4. Nurse and/or Designee reviewing missed medication and exception reports daily and following up as needed in conjunction with the nurse consultant to identify breakdown in the system. 5. Destruction of all discontinued and expired medications to be completed and logged by the Nurse consultant by 8/31/24. 6. Education to be completed with the nursing staff on process of removing and destroying medications that have expired or there is no longer an active order. Completed by 9/7/24. 7. Education to be completed with all RNs completing assessments on reviewing/reconciling medications during any comprehensive assessment or 90-Day Nurse Review.	

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S 565	Continued From page 8 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 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	S 565	8. RN and/or Designee will audit 15% of resident's medications to ensure medications are available per physicials orders and discontinued or expired meds are removed and destroyed per policy weekly x4 weeks, then monthly x5 months. Results of audits will be reviewed in quarterly QA x 6 months to ensure compliance.	

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S 565	Continued From page 9 personnel. This Requirement is not met as evidenced by: Based on surveyor observation, record review, and staff interview it has been determined that the facility failed to ensure medications were appropriately reconciled, administered, and disposed of in accordance with regulations for the singular resident reviewed relative to a medication error, ID #2. Findings are as follows: 1) According to Basic Nursing, Mosby 3rd, "the registered nurse checks all transcribed orders against the original order for accuracy and thoroughness. If an order seems incorrect or inappropriate, the nurse consults the physician." According to an Assisted Living Incident Required reporting form dated 7/11/2024, "[Resident ID #2] presented to the nurses station indicating [his/her] feet were swollen. Evaluation showed resident had bilateral leg edema 3+ pitting and swelling. During medication audit, it was discovered the resident has not received furosemide since medication added on 5/31/2024." Record review of the hospital visit report dated 7/11/2024 reveals the resident returned to the facility the same day after being given Lasix 20 MG IV, with an order to "continue current meds, elevate legs, return if any problems." During a surveyor record review and medication cart audit on 7/16/2024 from approximately 10:00 AM-1:00 PM it was discovered that Resident ID #2 has an active order for Furosemide dated 6/5/2024. During the time of the audit the	S 565		

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S 565	Continued From page 10 medication was still not available, despite the above-mentioned incident report and subsequent emergency room evaluation of Resident ID #2. Upon further review, the Administrator revealed Furosemide was ordered on 5/31/2024 and was discontinued on 6/3/2024. A new order was put in place by a staff nurse on 6/5/2024 without documentation from an ordering physician. The staff nurse who entered this order was on vacation and unable to be interviewed. Record review of Resident ID #2's medication administration record revealed Furosemide being signed as administered on, 7/1, 7/3, 7/5, 7/7, 7/9, 7/11, 7/13 and 7/15, despite the 7/16/2024 cart audit revealing it is not available. During an interview with the Director of Wellness on 7/22/2024 at approximately 3:30 PM, she was unable to provide evidence the medication was administered, as ordered, and the documentation of administration was accurate. 2) According to the Centers for Diseases Control and Prevention, "dispose of any unused or discontinued medications as soon as possible." During a facility medication cart audit on 7/16/2024 from 10:00 AM to 1:00 PM, it was discovered that Resident ID #2 had the following medication bottles stored in the medication cart without an active medication order: -Guaifenesin -Tadalafil -3 bottles of Prednisone, each with different directions for use During an additional interview the Administrator	S 565		

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S 565	Continued From page 11 acknowledged the medication administration record for Resident ID #2 was not accurate and medications were not administered as ordered. The Administrator and Director of Wellness were unable to provide evidence discontinued medications were removed from the cart to prevent errors from occurring.	S 565		