RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01495	A. BUILDING: _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN ASSISTED LIVING	55 TOLL GATE FARM ROAD 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 complaint/incident investigation survey, ACTS reference numbers 98663 and 98695, were conducted at this residence on 12/19/2024 to determine compliance with state regulations. A deficiency was identified.	S 003	Received JAN 16 2025 Facilities Regulation	
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 provide care and services in accordance with the prevailing community standards of care relative to following a physician's order for administration of medication for 1 of 3 sample residents reviewed, Resident ID #1. Findings are as follows: A community reported complaint filed with the Rhode Island Department of Health on	S 230	1/21/25 Corrective action was taken by; RN contacted the MD, Pharmacy and Family to get proper orders for medication. MD sent proper orders for resident to pharmacy and a copy was sent to our building. Medication discrepancy was resolved on 12/31/24. To avoid other residents who have the potential to be affected by the same deficiency we will; complete a medication audit of all medication orders to ensure we have updated and accurate current orders. This will be completed by 1/31/25	

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 1/16/25

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S 230	Continued From page 1 12/09/2024 alleges that Staff A, Certified Medication Technician (CMT), did not give Resident ID #1 the correct dose of valsartan (used to treat high blood pressure) for months. According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states in part, "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." Review of the facility's policy, "Administration of Medication" reveals under "Procedure-Duties and Responsibilities...compare medication label with Medication Sheet...Chart on medication Sheet correctly..." Review of the "Medication Aide" job description reveals, "...14. Ensure that all medications administered are properly labeled and match the MD (medical doctor) written order and med sheet..." Record review revealed Resident ID #1 moved into the residence in December of 2021 with a diagnosis including, but not limited to, hypertension (high blood pressure). Record review of the resident's medication list reveals an order dated 12/13/2021 for Valsartan 320 mg (milligrams) tabs (Diovan)-daily-PO (by mouth)-Take one tablet by mouth daily-8AM." Review of the Medication Administration Record (MAR) for August, September, October, and November of 2024, reveals an order for Valsartan "320 MG oral tablet. 1 Tablet by mouth One time per day Every day at 8:00 AM..." The record indicates the medication was given on all dates in	S 230	We have set up measures to ensure that this does not recur by; RN will be checking every medication order upon receipt. If there is an medication discrepancy with any medication orders we will contact the MD, Pharmacy and family within 24 hours to get clarification on the order. The correct signed orders will be sent to the pharmacy and to our building. The Nurse will document all correspondence in resident notes to ensure proper communication. Orders will be reviewed at the beginning of every month and upon receipt of new orders to monitor and ensure that residents have correct medication orders at all times.	

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S 230	Continued From page 2 the above-mentioned months. Record review of a pharmacy invoice dated 08/23/2024, revealed medication, "Valsartan Tabs Strength 40 mg. Qty (quanity):120..."You have 3 refill(s) before 08/16/2025. Refill after 09/03/2024..." Record review failed to reveal a nurse review with medication reconciliation was completed for this resident since September of 2023. Therefore, it is undetermined when the resident began receiving 40 mg tablets, rather than 320 mg tablets. Review of the progress notes reveals the following entries: -11/25/2024 "the resident received Valsartan 40 mg tablets last week with instructions to take 8 tabs. Resident only took 1 tablet that made 40 mg. Resident took Valsartan 320 mg yesterday. Resident took Valsartan 40 mg today..." Further review of the progress note reveals the physician was notified of the above. The physician recommended to continue Valsartan 320 mg daily. It is noted that the physician will update the resident's medication list so the order will read Valsartan 320 mg 1 tab daily. -11/26/2024 the resident took 80 mg of Valsartan of the 320 mg dose, as ordered. The physician was notified. -11/28/2024 the resident took 80 mg of Valsartan of the 320 mg dose, as ordered, no note that the physician was notified. -11/30/2024 the resident took 80 mg of Valsartan of the 320 mg dose, as ordered, no note that the physician was notified.	S 230		

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S 230	Continued From page 3 During a surveyor interview with Staff A, CMT, at 10:12 AM, she indicated that the pharmacy sent 40 mg tablets of Valsartan instead of the 320 mg tablets. She revealed that the resident is to take eight, 40 mg tablets, to equal the 320 mg dose. She further revealed that the resident is refusing to take the 8 pills of Valsartan daily. In addition, she revealed she noticed that the resident had been on the 40 mg tablets for 1-2 weeks. During a surveyor interview with the pharmacist at 2:00 PM, he revealed that in August and in September the physician's order was for the resident to receive 40 mg tabs, 8 tablets daily, to equal 320 mg. During a surveyor observation on 12/19/2024 at 10:12 AM of the medication cart, the resident's bottle of Valsartan 320 mg tablets was opened on 12/03/2024. During a surveyor interview with the resident's physician at 3:04 PM, she indicated that she didn't realize she had ordered the 40 mg tablets back in August and that the resident would have to take 8 tablets per day to equal the ordered dose of 320 mg daily. She further indicated she was not made aware that the resident was not taking the full dose of Valsartan 320 mg daily until the end of November. She further revealed she would have expected to be notified every time the resident did not receive his/her full dose of medication. During a surveyor interview on 12/19/2024 at approximately 3:30 PM, the Director of Wellness could not provide evidence that the resident's medications were delivered in a form consistent with the physician's order from August until	S 230		

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S 230	Continued From page 4 November, when it was identified by staff. Additionally, she could not provide evidence of that the resident's medications were reconciled. Furthermore, she could not provide evidence the physician was notified on every date the order was not followed, as she does not know when the resident began receiving 40 mg tablets of Valsartan rather than 320 mg.	S 230		