RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01509	A. BUILDING: _____ B. WING _____	C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STILLWATER ASSISTED LIVING AND SKILLED	20 AUSTIN AVENUE GREENVILLE, RI 02828

(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 was conducted at this residence on 8/14/2024. A deficiency was identified as a result of this survey.	S 003	The filing of this Plan of Correction (POC) does not constitute that the deficiencies alleged did in fact exist, rather this POC is filed as evidence of the facility's continuing commitment to high quality resident care in full compliance with state and federal regulations. Completion date for optimal compliance with POC will be September 14, 2024.	
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 prevailing community standards of care relative to skin assessment for "at risk" residents for a singular resident reviewed for wound care, Resident ID #1. Findings are as follows: According to AHCPR (Agency for HealthCare Policy and Research) Clinical Practice Guideline, Pressure Ulcers in Adults: Prediction & Prevention Number 3, May, 1992, the skin of the "at risk" patient should be inspected on admission and at least daily.	S 230	**As a Plan of Correction (POC) for Tag S230:** a) Resident ID#1 no longer resides at our facility as indicated in the state form of deficiencies. b) We recognize any resident may be at risk for a similar occurrence if skin is not routinely and thoroughly inspected by our staff. We had conducted a skin check for all residents (who would agree to this) shortly after this occurrence with no negative finings.	

RECEIVED
SEP 05 2024
FACILITIES REGULATION

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert Corrigan — TITLE: Administrator — (X6) DATE: 9/4/24

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S 230	Continued From page 1 According to Clinical Nursing Skills, 5th Edition, 2000, assessment requires skilled observation, reasoning, and a theoretical knowledge base to gather and differentiate, verify, organize data, and document the findings. Assessment is a critical phase because all the other steps in the process depend on the accuracy and reliability of the assessment. A community reported complaint submitted to the Rhode Island Department of Health on 8/1/2024 alleges that Resident ID #1 did not receive appropriate care resulting in skin breakdown. Within hours of transferring Resident ID #1 to another facility, the complainant was informed that the resident had a wound on his/her buttock with calcification (a gradual accumulation of calcium in body tissue. It can lead to hardening tissues when the calcium deposits and can affect organ function), indicating that the wound had been there "for quite a while." Record review revealed the resident moved into the residence in January of 2024 with diagnoses including, but not limited to, Alzheimer's disease, type 2 diabetes mellitus, neuropathy (numbness and pain from nerve damage usually in the hands and feet), foot wound, and vascular dementia. The resident resided on the secure care unit. Review of the resident's service plan, dated 1/17/2024, revealed the resident needs assistance with activities of daily living including hygiene, bathing, and dressing. Review of the resident's discharge continuity of care form dated 4/9/2024 revealed the resident's skin is free from decubitus ulcers (also known as a pressure ulcer, pressure sore, or bedsore, is an	S 230	c) The Director of Wellness has since revised our policy to include skin checks to be completed weekly (in addition to upon admission and discharge). We have also educated the nurses and CNAs to this revised policy. The Director of Wellness has also re-educated the care team (nurses and CNAs) on "how to" conduct a thorough body/skin check so as to ensure proper positioning of the resident to safeguard all parts of the body are viewable during this inspection. CNAs have been instructed to notify the nurse or Wellness Director of any occurrences when residents decline the body check and of course, to report any skin integrity issues timely. d) The Wellness Director is responsible for ensuring this POC is executed timely and effectively. We will conduct ongoing audits of weekly skin checks to ensure they are being done consistently and responded to when applicable. The audit findings will be shared with the QAPI Committee monthly for no less than the remainder of this year, after which time the QAPI Committee will evaluate our level of compliance/improvement and determine if we will "drop" the indicator or continue.	

Robert Corrigan Administrator 9/4/24

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S 230	Continued From page 2 open wound on the skin caused by prolonged pressure to a specific area of the body). The report indicates the resident has a left heel callous which requires daily skin preparation. Further review of the report reveals the resident requires limited assistance with toileting and utilizes adult briefs relative to urinary incontinence. The report further indicates the resident is "prone to UTIs (urinary tract infections)" and requires urinary incontinence care each shift. Record review of the skin assessment completed by the receiving facility, dated 4/9/2024, states in part, "...Skin Integrity...Pressure...2.5 cm(centimeters) 2.5cm 0.2 cm Unstageable (full thickness tissue loss in which the base of the ulcer is covered in slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed)...unstageable area to right ischium (lower and back sides of the hip bone) wound bed pink and yellow/white..." During a surveyor interview at approximately 12:45 PM with Nursing Assistant, Staff A, she revealed that she had given the resident a shower and had assisted the resident in the bathroom. She further revealed that sometimes the resident would use the bathroom without assistance. She acknowledged that she had not seen the resident's buttock wound during assistance with the resident's care. Review of a wound clinic progress note dated 4/23/2024 revealed the resident has a chronic Stage 3 pressure injury/pressure ulcer that has not healed. During a surveyor interview at 1:30 PM with the discharging Nurse, Staff B, she revealed she was	S 230		

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S 230	Continued From page 3 unaware that the resident had a wound on his/her buttock. She further revealed that the nursing assistants would inform her if they were to see any skin issues. She indicated the discharge continuity of care form was completed after the resident left the facility. Record review failed to reveal skin assessments accurately reflected the resident's skin condition and include all required components of appropriate wound documentation, including, but not limited to: measurements, staging, and descriptions of each wound. During a surveyor interview at 10:05 AM with the Administrator, he revealed that the residence doesn't have a license to provide wound care. He further revealed he wouldn't accept any resident with a wound. During a surveyor interview at 10:27 AM with the Director of Wellness, she revealed that only on admission and discharge were skin checks performed. She further revealed that the complainant sent pictures of the resident's wound a couple of days after the resident had been discharged from the residence, which revealed the resident had a Stage 3 pressure ulcer. She was unable to provide evidence that skin checks were performed on this resident, as required.	S 230		