RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01477	A. BUILDING: _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CENTRE OF NEW ENGLAND	600 CENTRE OF NEW ENGLAND COVENTRY, RI 02816

(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 7/22/2024. A deficiency was identified.	S 003	The following is the Plan of Correction for Brookdale Centre of New England regarding the Statement of Deficiencies from the community reported complaint investigation on July 22, 2024. This Plan of Correction is not to be construed as an admission of, or agreement with the findings and conclusions in the Statement of Deficiencies. Rather, it submitted as confirmation of our ongoing efforts to comply with statutory regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We remain committed to delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.	
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 a hospice recommendation for skin 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. Record review revealed the resident moved into the residence in February of 2019 with a	S 230 8/14/24	**2.4.13 (A/B) Management of Services** Recommendations for Resident #1 implemented Residents with third party services for skin care are at potential risk for deficient practice.	7/22/24

Facilities Regulation

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

Thomas Lacerne — Executive Director — 8-13-24

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S 230	Continued From page 1 diagnosis of dementia. Review of a "Hospice Care Coordination Note" dated 7/18/2024 under Coordination details: "...staff will use barrier cream starting tomorrow...Recommendation: 1. Apply barrier cream to red area (right buttocks) every brief change..." During a surveyor interview on 7/22/2024 at 1:30 PM with Medication Technician, Staff A, she revealed that she noticed the resident had a reddened area on his/her coccyx at the end of last week. She further revealed that she did incontinence care on the resident before lunch and was not aware that hospice recommended barrier cream for the resident during every brief change. During a surveyor interview on 7/22/2024 at 2:44 PM with the Health and Wellness Director, she revealed that she would expect a hospice recommendation to be implemented within 24 hours and no later than 48 hours. She acknowledged that the nurse failed to report the hospice recommendation to the physician and could not provide evidence that the resident was receiving barrier cream, as recommended.	S 230	An audit of current residents receiving third party services for skin care was conducted by the Health and Wellness Directors. No others recommendations or follow up needs were found. Clinical staff member counseled and educated on third party recommendations process. Clinical staff were retrained on monitoring and reviewing the Home Health/Hospice/Third Party Provider Collaboration Notes by the Health and Wellness Directors Home Health/Hospice/Third Party Provider Collaboration Notes will be available at the nurses desk on each unit. Staff nurses will review these notes within 48 hours to verify recommendations have been reported to the primary care provider and implemented accordingly. Weekly audits of the Home Health/Hospice/Third Party Provider Collaboration Notes will be completed by the Health and Wellness Directors or designee to verify compliance. Quarterly Quality Assurance review will be conducted by the HWD and/or Executive Director to verify compliance. ***Responsible: HWD and/or Executive Director.***	8/9/24 7/31/24 8/7/24 Ongoing 8/9/24 Ongoing **8/9/24** Ongoing **10/8/24** **Ongoing**