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 02/11/2025

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, ACTS reference numbers 98848, 99456, and 99517, was conducted at this residence on 2/11/2025 to determine compliance with state regulations. Deficiencies were identified.	S 003		
S 190	Organization And Management 2.4.12.H Administrative Management 2.4.12 (H) In-service Training 1. Employees shall have on-going, at intervals not to exceed twelve (12) months, in-service training as appropriate for their job classifications and including the topics cited in § 2.4.12(G) of this Part. 2. All new employee orientation and on-going in-service training shall be documented in the employee's personnel file, and maintained onsite at the licensed residence. 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 employees shall have initial and on-going, at intervals not to exceed twelve (12) months, in-service training in all required topics for 3 of 3 staff reviewed, Staff A, B, and C. Findings are as follows: Record review of personnel records and facility in-service training documents failed to reveal the following staff were in-serviced on all required topics identified in 2.4.12(G1) and 2.4.12(G2).	S 190	1. We have begun including in-services during each monthly All Staff Meeting. The completed in-services will be audited and any employee who does not attend complete in-service meeting will have a week to complete the assigned in-service or will be removed from the schedule until that in-service has been completed and turned into the Business Office. 2. All new employees files will be audited within one week's timeframe and will ensure all proper training and necessary licensure is documented in their employee file. After one week, if any documents are missing, the employee will be removed from the schedule until the appropriate education has been completed and submitted to Business Office. This will begin immediately during the March All Staff meeting on March 20, 2025. Facilities Regulation MAR 0 / 2025 Received 3/27/25	

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

Melissa Stark Executive Director

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S 190	Continued From page 1 According to 2.4.12(G1), the administrator shall ensure that all new employees shall receive at least two (2) hours of orientation and training within ten (10) days of hire and prior to beginning work in the assisted living residence. These trainings include the following: a. Fire prevention b. Recognition and reporting of abuse, neglect, and mistreatment c. Assisted living philosophy (goals/values: dignity, independence, autonomy, choice) d. Resident's rights e. Confidentiality f. Emergency preparedness and procedures g. Medical emergency procedures h. Infection control policies and procedures i. Resident elopement According to 2.4.12(G2), the administrator shall ensure that all new employees who will have regular contact with residents and provide residents with personal care shall receive at least ten (10) hours of orientation and training within thirty (30) days of hire and prior to beginning work alone in the assisted living residence. These trainings include the following: j. Basic sanitation k. Food service l. Basic knowledge of cultural differences m. Basic knowledge of aging-related behaviors including dementia and Alzheimer's disease n. Personal assistance o. Assistance with medications p. Safety of residents q. Body Mechanics i. Resident Transfers (required for residences licensed at the F1 level for fire safety) j. Record-keeping	S 190	The Executive Director will evaluate the orientation scheduled in-services to ensure full compliance and will replace or add any missing or incorrect in-services. Specifically, the Executive Director will look for Fire Prevention and Emergency Preparedness and Procedures training to be added to the upcoming orientations. We will also ensure ALL staff completes the new trainings for Fire Prevention and Emergency Preparedness and Procedures. When auditing the new employee files (see above), we will also ensure all proper education has been completed. Some time is asked to find the proper training. We will have the new training implemented by April All Staff Meeting on April 17, 2025.	

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S 190	Continued From page 2 k. Service plans l. Internal reporting. Staff A was rehired as a Certified Medication Technician (CMT)/Nursing Assistant (NA) in September of 2024. Review of the record revealed incomplete hire trainings on fire prevention, assisted living philosophy, resident's rights, emergency preparedness and procedures, medical emergency procedures, infection control policies and procedures, basic sanitation, food service, basic knowledge of cultural differences, personal assistance, assistance with medications, safety of residents, body mechanics, resident transfers, record keeping, and service plans.. Staff B was hired as a Server on 1/21/2025. Review of the record revealed incomplete in-service trainings on medical emergency procedures and fire prevention. Staff C was hired as a NA on 1/21/2025. Review of the record revealed incomplete in-service trainings on medical emergency procedures and fire prevention. During a surveyor interview with the Executive Director on 2/11/2025 at 1:20 PM, she could not provide evidence that the above-mentioned required trainings were completed.	S 190		
S 233	Organization And Management 2.4.13.B Management Of Services B. The residence shall have a policy and procedure manual that is reviewed and updated by the administrator at intervals not to exceed twelve (12) months, and shall include, but not be	S 233		

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S 233	Continued From page 3 limited to, the following items: 1. A written description of all services available to residents that shall be designed to promote the resident's efforts to maintain independence; 2. A written statement of admission criteria that shall include, at a minimum, the following information regarding the resident population: a. Nature and extent of disabling condition(s) served; and b. Restrictions (if any). (1) The statement of admission criteria shall include a statement that no otherwise qualified applicant shall be denied admission to the residence solely on the basis of race, creed, color, religion, sexual orientation, or national origin. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to have a policy and procedure manual that is reviewed and updated by the residence at intervals not to exceed twelve months. Findings are as follows: Record review of the policy and procedure manual failed to reveal evidence that it has been reviewed and updated yearly. Facility policies did not have an initial date or any dates of review. During a surveyor interview with the Administrator on 2/11/2025 at 1:45 PM, she could not provide	S 233	After fully reviewing the current policies and procedures manual, the Executive Director has decided to purchase a new Policies and Procedures manual through the AHCA/NCAL website. The Executive Director will update, along with the owner, to create the policies of the building. The binder will be completed, reviewed and signed and dated. The Executive Director will also create binders for each Dept Head which will contain all P&Ps that relate to each individual department. This project will be completed by April 30, 2025.	

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S 233	Continued From page 4 evidence that the policy and procedure manual had been updated at intervals not to exceed twelve months, as required.	S 233		
S 275	Organization And Management 2.4.13.K Management Of Services 2.4.13 (K) Advance Directives 1. The residence shall have written policies and procedures that address advanced directives that shall include, but not be limited to, sufficient instructions for employees to follow in the event of emergencies and the resuscitation of residents. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to have procedures that address advanced directives that shall include, but not be limited to, sufficient instructions for employees to follow in the event of emergencies and the resuscitation of residents. Findings are as follows: Review of a "Code Status-Informed Consent Form" states in part, "...Full Code which is defined as any and all means both mechanical and physical to revive a resident in the event of a cardiac and/or respiratory arrest. DNR (Do Not Resuscitate) which is defined as the withholding of any and all means both mechanical and physical to revive a resident in the event of a cardiac and/or respiratory arrest. A DNR order would include withholding means to maintain life such as external chest massage, intubation and	S 275	While creating the above policies and procedures manual, the Executive Director will ensure there is a policy written that will address Advance Directives and ensure it includes instructions for employees. We will also ensure this is added to this year's education and audit to ensure ALL staff are fully educated on how to handle emergency situations, including a resident's Advance Directives. This will be completed no later than the April 30, 2025 deadline with the about Policies and Procedures manual.	

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S 275	Continued From page 5 defibrillation..." The residence policy titled "Communication of Code Status" states in part, "...It is the policy of the facility to adhere to resident's rights to formulate advance directives. In accordance to these rights, this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information. Policy Explanation and Compliance Guidelines:...When an order is written pertaining to a resident's presence or absence of an Advance Directive, the directions will be clearly documented in designated sections of the medical record. Examples of directions to be documented include but are not limited to: a. Full Code b. Do Not Resuscitate...The designated sections of the medical record are: in the front flap of record. Additional means of communication of code status include: within record on Point Click Care..." Record review revealed Resident ID #1 moved into the residence in October of 2023 with diagnoses including, but not limited to, chronic obstructive pulmonary disease. Record review of a progress noted dated 1/28/2025 states in part, "...CMT (Certified Medication Technician) responded to resident call pendant this AM at 04:30, observed resident on [his/her] knees beside bed with pallor (an unhealthy pale appearance). EMS (emergency medical services) activated and transported..." Review of a statement from Nursing Assistant (NA), Staff D, dated 1/28/2025 revealed she witnessed the resident kneeling on the floor unresponsive. Her statement further revealed that CMT, Staff A, came to assist her then left to	S 275		

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S 275	Continued From page 6 check the resident's code status and call 911. Review of the emergency medical service report dated 1/28/2025 revealed they received a call from this residence revealing that the resident was not breathing. Upon arrival the resident was found on the floor with his/her knees tucked up underneath him/her and his/her arms extended by his/her side. The resident was cyanotic (a bluish-purple discoloration of the skin, lips, and nail beds caused by a deficiency in oxygen in the blood), not breathing, and no pulse. CPR was initiated upon arrival. During surveyor interviews with facility staff, 4 out of 5 staff interviewed were unable to communicate what the protocol was for an emergency medical event. During a surveyor interview with the Director of Wellness, DOW, at 11:02 AM, she revealed Staff A went into the resident's room because the resident used his/her pendant, at this time the resident was unable to be located. When the resident was eventually found in his/her room, he/she was found in a kneeling position, inbetween the bed and the wall, unresponsive. She further revealed Staff D stayed with the resident while Staff A went to call 911. She indicated that they could not get the resident in a position to do CPR. Record review revealed the resident's code status is "Do Not Resuscitate", the resident signed this document on 11/7/2023 and the resident's physician signed it on 11/9/2023. During a subsequent interview with the DOW, she revealed that when the emergency medical technician arrived, CPR was immediately started	S 275		

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S 275	Continued From page 7 as Staff A could not find the resident's advance directive in the resident's paper chart and she failed to look in the resident's electronic medical record to find it. Furthermore, she could not provide evidence that staff followed the resident's code status of DNR.	S 275		
S 350	Residency Requirements 2.4.16.A Resident Assessment/Service Plans 2.4.16 (A) Resident Assessments and Service Plans A. Prior to the admission of a resident, or the signing of a residency agreement with a resident, the administrator shall have a comprehensive assessment of the resident's health, physical, social, functional, activity, and cognitive needs and preferences conducted and signed by a registered nurse. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to perform a comprehensive assessment that was completed in its entirety for 1 out of 3 residents reviewed, Resident ID #2. Findings are as follows: Record review revealed Resident ID #2 moved into the residence on 2/3/2025 with diagnoses of hypertension, atrial fibrillation, and peripheral vertigo.	S 350	The Executive Director will ensure to be more careful in reviewing the Resident Assessments before signing off on them. The Director of Wellness will also look over the assessments before they are given to the Executive Director for review. This process will begin immediately. 3/10/25	

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S 350	Continued From page 8 Record review of the resident's comprehensive assessment, dated 1/30/2025, revealed "Section 4 -Behavioral Information" was blank. Section 4 contains important information including, but not limited to: wandering, assaultive/destructive behavior, danger to self, and self-preservation. During a surveyor interview with the Director of Wellness on 2/11/2025 at approximately 3:30 PM, she was unable to provide evidence that all sections on the comprehensive assessment form were completed.	S 350		