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 _____ | 09/01/2023 |

| 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 |
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| S 003 | Initial Comments<br><br>An biennial State Licensure survey was conducted at this residence on 8/31/2023 through 9/1/2023. Deficiencies were identified relative to the State Licensure survey. | S 003 | RECEIVED SEP 21 2023 FACILITIES REGULATION<br><br>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 October 6, 2023. | |
| S 180 | Organization And Management 2.4.12.G.1 Administrative Management<br><br>2.4.12 (G) (1) Employee Training<br><br>1. 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 alone in the assisted living residence, in addition to any training that may be required for a specific job classification at the residence. Such areas include:<br><br>a. Fire prevention;<br><br>b. Recognition and reporting of abuse, neglect, and mistreatment;<br><br>c. Assisted living philosophy (goals/values: dignity, independence, autonomy, choice);<br><br>d. Resident's rights;<br><br>e. Confidentiality.<br><br>f. Emergency preparedness and procedures;<br><br>g. Medical emergency procedures;<br><br>h. Infection control policies and procedures; and | S 180 | AB 9/21/23<br><br>**As a Plan of Correction (POC) for Tag S 180:**<br><br>a) There were no residents identified in this tag. Staff A and D are no longer employed at the Assisted Living (AL) Residence. Staff B, C and E have since received the necessary training per regulatory requirement.<br>b) Although there were no residents identified in this tag, we recognize the potential risk to our resident population if staff are not properly trained upon hire and have responded to this concern. | |

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

Robert Cousins - Administrator — 9/19/23

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| S 180 | Continued From page 1<br>i. Resident elopement.<br><br>This Requirement is not met as evidenced by:<br>Based on record review and staff interview, it has been determined the residence failed to ensure all new employees received at least two hours of orientation and training within ten days of hire and prior to beginning work alone in the residence, in the areas specific to job classification stipulated in §2.4.12(G)(1) of the regulations for 5 of 9 sample employees, Staff A, B, C, D, and E.<br><br>Findings are as follows:<br><br>1. Record review of Staff A revealed a hire date of 5/4/2023. This employee was hired as a Certified Nursing Assistant (CNA).<br><br>2. Record review of Staff B revealed a hire date of 2/7/2023. This employee was hired as a CNA.<br><br>3. Record review of Staff C revealed a hire date of 7/31/2023. This employee was hired as a CNA.<br><br>4. Record review of Staff D revealed a hire date of 7/11/2023. This employee was hired as a CNA.<br><br>5. Record review of Staff E revealed a hire date of 5/16/2023. This employee was hired as a CNA.<br><br>Record review of the personnel records for the above-mentioned staff failed to reveal evidence that the staff received at least two hours of orientation and training within ten days of hire and prior to beginning work alone in the residence.<br><br>During an interview on 9/1/2023 at 10:05 AM, the Director of Wellness could not provide evidence | S 180 | c) We have since completed the required education for those staff members identified in this tag and any new employees (within 10 days of hire). Our Wellness director and Administrator will ensure that any new hires receive the proper training within the time frame allotted per regulation. The Wellness Director and/or Administrator will review the new employees' file by day 10 of hire to ensure all required elements have been completed.<br>d) Our Wellness Director and Administrator will monitor compliance with these rules to ensure all newly hired staff are trained in a timely manner. The Administrator is ultimately responsible for ensuring these processes are in place and effective. Random and routine audits will be conducted by the Wellness Director/designee and/or Administrator to ensure newly hired employee files reflect completion of all training. Results of the audits being done will be shared with the QAPI Committee monthly for no less than 3 months. After this time period, the QAPI Committee will evaluate our level of compliance and improvement to determine the need to continue or discontinue based on our audit results. | |

9/24/23

RI Department of Health

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| S 180 | Continued From page 2<br>that the above employees had received the required training. | S 180 | **As a POC for Tag S365:**<br>a) Resident ID#1 is no longer at the AL Residence.<br>b) We have since reviewed the resident population to ensure any other significant changes in condition have been identified and resident assessments and service plans revised accordingly if applicable.<br>c) The Wellness Director has reviewed the resident population to ensure any significant clinical changes have been identified timely and the resident assessments and service plans revised accordingly. The Wellness Director and Nurses will discuss and communicate any significant changes in resident status on a routine basis at morning meetings and routine rounding. The nurses have been re-educated regarding the importance of timely updates to resident assessments and service plans.<br>d) Our Wellness Director/designee is responsible for ensuring timely updates to resident assessments and service plans. Random and routine audits will be conducted by the Wellness Director/designee to ensure timely completion of these changes when applicable. Results of the audits being done will be shared with the QAPI Committee monthly for no less than 3 months. After this time period, the QAPI Committee will evaluate our level of compliance and improvement to determine the need to continue or discontinue based on our audit results. | |
| S 365 | Residency Requirements 2.4.16.D Resident Assessment/Service Plans<br><br>2.4.16 (d) Resident Assessments and Service Plans<br><br>D. The assessment shall be reviewed and at intervals not to exceed twelve (12) months and each time a resident's condition changes significantly.<br><br>This Requirement is not met as evidenced by:<br>Based on record review and staff interview, it has been determined the residence failed to review the comprehensive assessment each time a resident's condition changes significantly, and failed to accurately reflect that the resident is receiving outside service for 1 of 3 sample residents reviewed, Resident ID #1.<br><br>Findings are as follows:<br><br>Record review revealed the resident moved into the residence in March of 2020. S/he has a diagnosis of dementia.<br><br>Record review of a list of residents receiving outside services provided by the Director of Wellness revealed the resident is receiving hospice services with a start of care date of 8/10/2023.<br><br>Record review of a comprehensive assessment dated 1/20/2023 failed to reveal that the assessment was updated to reflect the resident is | S 365 | | |

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| S 365 | Continued From page 3<br>receiving hospice services.<br><br>During a surveyor interview on 8/31/2023 at 2:23 PM with the Director of Wellness, she acknowledged the resident is receiving hospice services. Additionally, she acknowledged the assessment was not updated to reflect the outside service provided to the resident. | S 365 | **As a POC for Tag S390:**<br><br>a) Resident ID#1 is no longer at the AL Residence.<br>b) We have since reviewed the resident population to ensure any additional outside services (such as Hospice) are reflected in the individuals' service plan.<br>c) The Wellness Director has reviewed the resident population to ensure any additional (outside) services are reflected in the service plans revised accordingly. The Wellness Director and Nurses will discuss and communicate any significant changes in resident status on a routine basis at morning meetings and routine rounding. The nurses have been re-educated regarding the importance of timely updates to resident assessments and service plans.<br>d) Our Wellness Director/designee is responsible for ensuring timely updates to resident assessments and service plans. Random and routine audits will be conducted by the Wellness Director/designee to ensure timely completion of these changes when applicable. Results of the audits being done will be shared with the QAPI Committee monthly for no less than 3 months. After this time period, the QAPI Committee will evaluate our level of compliance and improvement to determine the need to continue or discontinue based on our audit results. | |
| S 390 | Residency Requirements 2.4.16.G.3 Resident Assessment/Service Plan<br><br>2.4.16 (G)(3) Service Plans<br><br>3. The service plan shall be reviewed by both parties at intervals not to exceed twelve (12) months and each time a resident's condition changes significantly and all changes shall be acknowledged in writing by both parties.<br><br>This Requirement is not met as evidenced by:<br>Based on record review and staff interview, it has been determined the residence failed to review the service plan each time a resident's condition changes significantly and failed to accurately reflect that the resident is receiving outside services for 1 of 3 sample residents reviewed, Resident ID #1.<br><br>Findings are as follows:<br><br>Record review revealed the resident moved into the residence in March of 2020. S/he has a diagnosis of dementia.<br><br>Record review of a list of residents receiving outside services provided by the Director of Wellness revealed the resident is receiving | S 390 | | |

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| S 390 | Continued From page 4<br>hospice services with a start of care date of 8/10/2023.<br><br>Record review of a service plan dated 1/26/2023 failed to reveal that the service plan was updated to reflect the resident is receiving hospice services.<br><br>During a surveyor interview on 8/31/2023 at 2:23 PM with the Director of Wellness, she acknowledged the resident is receiving hospice services. Additionally, she acknowledged the service plan was not updated to reflect the outside service provided to the resident. | S 390 | | |
| S 565 | Residential Care Services 2.4.24.B.1 Medication Services<br><br>2.4.24 (B) (1) Administration of Medications<br><br>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.<br><br>a. The resident or guardian must provide written authorization for the residence to provide administration of medications.<br><br>b. Medications shall be administered in 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. | S 565 | **As a POC for Tag S565:**<br><br>a) The medications noted in the 2567 have since been labeled accordingly. There were no particular residents noted in the tag.<br>b) All medications carts have been reviewed to ensure medications are properly labeled with a resident identifier and directions for use.<br>c) The Wellness Director has since provided the CNA/CMTs with re-education regarding the regulatory requirements for safe administration in regard to proper labeling of medications (to include resident identifier and instructions for use). The Wellness Director/designee will conduct random audits of the medications carts to ensure proper labeling of medications in place. | |

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| S 565 | Continued From page 5<br>c. All medications must be checked against a physician's orders by a licensed nurse, or pharmacist.<br><br>d. The resident must be identified prior to administration of any medication.<br><br>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.<br><br>f. Injectable medications, including but not limited to insulin, which cannot be self-administered by the resident, must be administered by a licensed nurse.<br><br>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).<br><br>(1) The legal destruction of hypodermic needles, syringes or other such instruments is the responsibility of the last entitled or authorized possessor.<br><br>(AA) All personnel or residents legally authorized to use disposal syringes and needles, shall destroy them after one (1) use.<br><br>(BB) Excess and undesired needles, 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. | S 565 | d) Our Wellness Director/designee is responsible for ensuring execution of this plan. Random and routine audits will be conducted by the Wellness Director/designee to ensure medications are labeled accordingly. Results of the audits being done will be shared with the QAPI Committee monthly for no less than 3 months. After this time period, the QAPI Committee will evaluate our level of compliance and improvement to determine the need to continue or discontinue based on our audit results. | 9/21/23 |

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| S 565 | Continued From page 6<br>(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.<br><br>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.<br><br>i. Any medication administered by the residence and refused by a resident shall be documented and reported, as appropriate.<br><br>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.<br><br>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.<br><br>l. All centrally stored medications shall be maintained in accordance with manufacturer's labeling and administered by authorized personnel.<br><br>This Requirement is not met as evidenced by:<br>Based on surveyor observation and staff interview, it has been determined the residence | S 565 | | |

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| S 565 | Continued From page 7<br>failed to ensure that medications shall be stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access for 3 of 3 medication carts observed, the first floor, the Camelot unit, and the Memory Lane unit medication carts.<br><br>Findings are as follows:<br><br>1. During a surveyor observation of the first floor medication cart on 8/31/2023 at 10:35 AM in the presence of a Certified Medication Technician (CMT), Staff F, the following medications were observed without a resident identifier and directions for use:<br><br>- Vitamin D3 50 mcg (microgram)<br>- Cranberry 500 mg (milligram)<br>- Stool Softener 100 mg<br>- Pharbetol 500 mg<br>- Tylenol extra strength 500 mg<br><br>During an interview with Staff F immediately following this observation, she acknowledged the above medications did not have a resident identifier and directions for use.<br><br>2. During a surveyor observation of the Camelot unit medication cart on 8/31/2023 at 10:40 AM in the presence of a CMT, Staff G, the following medications were observed without a resident identifier and directions for use:<br><br>- Acetaminophen 500 mg<br>- Melatonin 3 mg<br>- Two bottles of antacid 750 mg<br>- Stool Softener 100 mg<br><br>During an interview with Staff G immediately following this observation, she acknowledged the | S 565 | | |

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| S 565 | Continued From page 8<br>above medications did not have a resident identifier and directions for use.<br><br>3. During a surveyor observation of the Memory Lane unit medication cart on 8/31/2023 at 10:55 AM in the presence of a CMT, Staff G, the following medications were observed without a resident identifier and directions for use:<br><br>- Ibuprofen 200 mg<br>- Vitamin D3 50 mcg<br><br>During an interview with Staff G immediately following this observation, she acknowledged the above medications did not have a resident identifier and directions for use.<br><br>During an interview on 9/1/2023 at approximately 11:40 AM with the Director of Wellness, she could not provide evidence the medications listed above had an indication of the residents' identifier and directions for use. | S 565 | | |