RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01520	A. BUILDING: _____ B. WING _____	C 12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPEL HILL	10 OLD DIAMOND HILL ROAD CUMBERLAND, RI 02864

(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 98341, 98230, 98194, 98137, 98357, 98079, and 97984, was conducted at this residence on 12/03/2024 to determine compliance with state regulations. A deficiency was identified.	S 003	The filling of this plan of correction does not constitute an admission of the allegations set forth in this statement of deficiencies.This plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law. RECEIVED DEC 31 2024 FACILITIES REGULATION	
S 365	Residency Requirements 2.4.16.D Resident Assessment/Service Plans 2.4.16 (d) Resident Assessments and Service Plans D. The assessment shall be reviewed and at intervals not to exceed twelve (12) months and each time a resident's condition changes significantly. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined that the residence failed to update the comprehensive assessment each time a resident's condition changed significantly for 2 of 3 residents reviewed for outside services, Resident ID #s 1 and 2. Findings are as follows: 1. Record review revealed Resident ID #1 moved into the residence in March of 2024 with a diagnosis including, but not limited to, osteoarthritis. Record review of the resident's comprehensive assessment dated 6/17/2024 revealed the assessment failed to be updated to document that the resident is receiving physical therapy	S 365 CM 1/6/25	1. In-service to be completed with nursing department on adding 3rd party provider services to the service plan. Completed by 1/10/25 2. 90-Day Nurse Review in PCC was updated with question regarding 3rd party services to ensure we are capturing it as well as who's providing it. 3. Resident ID #1 and ID # 2's service plans have been updated to reflect the 3rd party services being provided. 4. Audit of all service plans of residents receiving 3rd party services will be completed by 1/10/25 and updated as needed. 5. WD and/or Designee will review residents receiving outside services in weekly risk meeting. 6. WD and/or Designee will audit 10% of residents service plans to ensure the outside services are captured on the service plan weekly x4 weeks then mothly x 5 months and results of audit will be reviewed in quarterly QA x 6 months to ensure compliance.	1/10/25

Facilities Regulation

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

12-31-2024

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S 365	Continued From page 1 ~~(PT) services beginning on 11/13/2024.~~ During a surveyor interview with the Director of Wellness at 12:30 PM, she could not provide evidence that Resident ID #1's comprehensive assessment accurately reflected the resident's receipt of PT services. 2. Record review revealed Resident ID #2 moved into the residence in December of 2022 with a diagnosis including, but not limited to, dementia. Record review of the resident's comprehensive assessment dated 6/10/2024 revealed the assessment failed to be updated to document that the resident is receiving PT services beginning on 11/16/2024 and skilled nursing (SN) services beginning on 11/22/2024. During a surveyor interview with the Director of Wellness at 12:30 PM, she could not provide evidence that Resident ID #2's comprehensive assessment accurately reflected the resident's receipt of PT and SN services.	S 365		