RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01346	A. BUILDING: _____ B. WING _____	03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	964 MAIN STREET PAWTUCKET, RI 02860

(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 biennial State Licensure survey was conducted at this residence. Deficiencies were identified.	S 003	**S190 ORGANIZATION AND MANAGEMENT 2.4.12(H) ADMINISTRATION MANAGEMENT** **2.4.12 (H) In-Service Training**	
S 190 DTP 4/15/22	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 the residence failed to ensure that new staff received in-servicing training within ten (10) days of hire and prior to beginning work alone and existing staff received on-going, at intervals not to exceed twelve (12) months, in-service training for five of six sample employees, Staff ID's A,B,C,D, and E. Findings are as follows: 1) Record review of Staff A revealed a hire date of 08/15/2019. This employee was hired as a Registered Nurse/Director of Wellness. 2) Record review of Staff B revealed a hire date of 11/19/2020. This employee was hired as a	S 190	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Corrective action was taken in which Staff A, B, C, D, and E in which signed documentation of their completed mandatory in-service training was filed in their personnel record. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** An audit of all assisted living staff members' personnel files will be conducted for documentation of mandatory in-service training. Staff members will complete the mandatory annual in-service training if not documented in their personnel files. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Monthly audits will be conducted to ensure the completion and documentation of staff members' annual mandatory in-service education.	4/5/2022 4/5/2022

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alicia Curtis	Administrator	4/5/2022

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S 190	Continued From page 1 Certified Medication Technician (CMT)/Certified Nursing Assistant (CNA). 3) Record review of Staff C revealed a hire date of 03/17/2017. This employee was hired as a CMT/CNA. 4) Record review of Staff D revealed a hire date of 11/04/1997. This employee was hired as a CNA. 5) Record review of Staff E revealed a hire date of 07/19/2019. This employee was hired as CMT/CNA. Record review failed to reveal evidence that the above employees had received all required in-service training in the following areas prior to working alone: 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; 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;	S 190	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Director of Nursing/ designee will monitor the monthly audits for compliance with the plan of correction. The results of these audits will be submitted monthly to the interdisciplinary QA committee for (6) months to ensure continued compliance.	

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S 190	Continued From page 2 i. Resident Transfers (required for residences licensed at the F1 level for fire safety); j. Record-keeping; k. Service plans; and l. Internal reporting. During an interview on 03/10/2022 at approximately 4:45 PM, the Administrator was unable to provide evidence that the above employees had received all required in-service training annually.	S 190	**S200 ORGANIZATION AND MANAGEMENT 2.14.12(1)(2) ADMINISTRATIVE MANAGEMENT** **2.4.12(1)(2) Personnel Records** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Corrective action was taken to ensure that Staff A, B, C, D, E and F had a signed copy of. The employee's awareness of resident's rights in their personnel file. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** An audit of all assisted living staff members' personnel files will be conducted by the Human Resource Director/designee for documentation of a signed copy of the employee's awareness of resident's rights. If any assisted living staff member does not have a signed copy of his/her awareness of resident's rights, the staff will be given a copy of the resident rights for assisted living residents and a sign copy will be placed in his/her personnel file.	4/5/2022 4/5/2022
S 200	Organization And Management 2.4.12(I)(2) Administrative Management 2.4.12 (I) (2) Personnel Records 2. Said personnel records shall be reviewed and updated at intervals not to exceed twelve (12) months and shall include, but not be limited to, all of the following components: a. Completed job application and/or resume; b. Written statements of references or documentation of verbal reference check; c. Written functional job descriptions; (1) These descriptions shall be updated at intervals not to exceed twelve (12) months and shall include, but not be limited to, minimal qualifications for the position, major duties and responsibilities, and shall be signed and dated by the individual employee. d. Evidence of credentials, current professional licensure and/or certification;	S 200		

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S 200	Continued From page 3 e. Documentation of education and/or continuing training, including continuing education units (CEUs) related to administrator certification, food management, etc., medication administration, and dementia care; f. Documentation of attendance at in-service training and/or orientation; g. Documentation of at least one (1) performance evaluation at intervals not to exceed twelve (12) months; h. Signed copy of employee's awareness of resident's rights; i. Results of the criminal record (BCI) check. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to ensure personnel records contained a signed copy of employee's awareness of resident's rights for six of six employees reviewed, Staff A,B,C,D,E, and F. Findings are as follows: 1) Record review of Staff A revealed a hire date of 08/15/2019. This employee was hired as a Registered Nurse/Director of Wellness. 2) Record review of Staff B revealed a hire date of 11/19/2020. This employee was hired as a Certified Medication Technician (CMT)/Certified Nursing Assistant (CNA). 3) Record review of Staff C revealed a hire date of 03/17/2017. This employee was hired as a	S 200	**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Human Resource Director will perform random monthly review of assisted living employees' personnel files to ensure that all files have a signed copy of the employee's awareness of resident rights. This document will be included in the orientation packet for all new Assisted Living employees. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The finding of these audits will be monitored by the Director of Nursing/designee and submitted to the monthly QA interdisciplinary meeting for (6) months or until continued compliance is met with this plan of correction.	

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S 200	Continued From page 4 CMT/CNA. 4) Record review of Staff D revealed a hire date of 11/04/1997. This employee was hired as a CNA. 5) Record review of Staff E revealed a hire date of 07/19/2019. This employee was hired as CMT/CNA. 6) Record review of Staff F revealed a hire date of 11/01/2021. This employee was hired as a CMT/CNA. Record review failed to reveal evidence that the above employees had a signed copy of employee's awareness of resident's rights. During an interview on 03/10/2022 at approximately 5:10 PM, the Administrator was unable to provide evidence the above employees personnel records contained a signed copy of employee's awareness of resident's rights.	S 200		
S 360	Residency Requirements 2.4.16(C) Resident Assessment/Service Plans 2.4.16 (C) Resident Assessments and Service Plans C. The Department-approved assessment form, or such other assessment form as approved by the Department, shall be utilized in completing the assessment on each resident who is admitted to the residence. (Approved Department form is available for downloading online at http://health.ri.gov/forms/assessment/AssistedLivingResident.pdf).	S 360		

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S 360	Continued From page 5 1. Assisted living residences not intending to use the Department's assessment form shall submit their proposed assessment forms with a cover letter of intent to the Center for Health Facilities Regulation as specified in § 2.4.6(A) of this Part. 2. All assessment forms shall report information appropriate to determine compatibility and compliance with the residency criteria, and shall indicate that the resident's needs can be met by the assisted living residence within its licensure level, and shall gather information appropriate for the development of an individualized service plan. a. The assessment form shall be designed to demonstrate compliance with the assisted living residence's criteria for residency. b. The assessment form shall also be designed to demonstrate that the assisted living residence can meet the resident's needs and preferences. 3. The assessment form shall also be designed to provide information appropriate for the development of an individualized service plan in accordance with § 2.4.16(G)(1) of this Part. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence's assessment form failed to report the resident's needs and gather information appropriate for the development of an individualized service plan, for two of four sample residents reviewed, Resident ID#'s 1 and 2. Findings are as follows: 1) Record review revealed Resident ID #1 was	S 360	**S360 RESIDENCY REQUIREMENTS 2.4.16 (C) RESDIENT ASSESSMENT/SERVICE PLANS** **2.4.16(C) Resident Assessments and Service Plans** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Corrective action was taken immediately on 3/10/2022 and corrections were made to the comprehensive assessment and service plans of Resident ID #1 and #2. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** An audit of all assisted living residents' comprehensive assessments and service plans will be completed by the Director of Nursing/designee for accuracy and updated if necessary. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Director of Nursing/designee will complete random monthly audits for the next three months to ensure that the comprehensive assessments and service plans are accurate and reflect the necessary care of the residents.	3/10/2022 4/5/2022

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S 360	Continued From page 6 admitted in July of 2019. The comprehensive assessment dated 07/19/2019, updated on 07/24/2020 and 07/28/2021, states in part, "...Resident will self administer medication ...Resident has cognitive ability to self administer...no...daughter sets up..." Record review of Resident ID #1's physician's orders revealed an order dated 08/28/2019 which states, "AL staff will set up meds in pill organizer every evening shift starting on the 28th and ending on the 28th every month for monitoring med compliance and promote safety with meds." 2) Record review revealed Resident ID #2 was admitted in August of 2019. The comprehensive assessment dated 08/09/2019, updated on 08/11/2020 and 05/28/2021, states in part, "...Resident Will self administer medications ...sister will organize pill box..." Review of Resident ID #2's "Registered Nurse Reviews" dated 02/22/2022, 05/23/2021, and 04/27/2021 revealed they state, "staff administers medications." Review of Resident ID #2's "Service Plan" dated 05/05/2021 revealed medications are administered by staff. During an interview on 03/10/2022 at approximately 4:20 PM, the Director of Wellness acknowledged Resident ID #1 and 2's comprehensive assessments do not accurately reflect their medication administration status.	S 360	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The finding of these audits will be monitored by the Director of Nursing/designee and submitted to the monthly QA interdisciplinary meeting for (6) months or until continued compliance is met with this plan of correction.	
S 510	Residential Care Services 2.4.21(G)(1-4) Dietetic Services	S 510		

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S 510	Continued From page 7 2.4.21 (G) (1-4) Dietetic Services G. All food services shall be conducted in accordance with the rules and regulations pertaining to Certification of Managers in Food Safety (Part 50-10-2 of this Title) that include but are not limited to the following provisions: 1. Each residence where potentially hazardous foods are prepared shall employ at least one (1) full-time, on-site manager certified in food safety who is at least eighteen (18) years of age. 2. Residences that primarily serve the elderly and individuals with diminished immune systems shall have a manager certified in food safety present during preparation of all hot potentially hazardous foods. 3. Residences that have a licensed capacity of twenty-six (26) or more residents and that employ ten (10) or more full-time equivalent employees directly involved in food preparation shall employ at least two (2) full time, on-site managers certified in food safety. 4. Residences that have a licensed capacity of twenty-five (25) or fewer residents and that employ five (5) or fewer full-time equivalent employees involved in preparation and serving of food, shall only be required to employ one (1) full time manager certified in food safety. This Requirement is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the residence has failed to employ managers	S 510		

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S 510	Continued From page 8 certified in food safety as required. Findings are as follows: Residences that have a licensed capacity of twenty-six (26) or more residents are required to employ at least two (2) full time, on-site managers certified in food safety and have a manager certified in food safety present during preparation of all hot potentially hazardous foods. Observation of the kitchen on 03/10/2022 at approximately 11:40 AM revealed three expired Rhode Island Food Manager Certifications and two active certifications. The active certifications belonged to Staff G and the Food Service Director (FSD). During an interview at this time, the FSD acknowledged only she and her assistant have an active Rhode Island Food Manager Certification. Record review revealed Staff H had a Rhode Island Food Manager Certification which expired on 04/19/2021. This certification failed to be renewed upon expiration. Record review revealed Staff I had a Rhode Island Food Manager Certification which expired on 02/21/2021. This certification failed to be renewed upon expiration. Record review revealed Staff J had a Rhode Island Food Manager Certification which expired on 05/22/2021. This certification failed to be renewed upon expiration. Record review of the kitchen schedule from 02/01/2022-03/10/2022 revealed on the following dates hot food was prepared without a staff	S 510	**S510 RESIDENTIAL CARE SERVICES 2.4.21(G)(1-4) DIETETIC SERVICES** **2.4.21 (g) (1-4) Dietetic Services** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Upon receiving notification of survey results on 3/23/2022, corrective action was taken immediately by the Dietary Manager and Human Resource Director to train and recertified two staff members in Rhode Island Food Manager Certification. The Dietary Manager will reschedule staff hours to ensure that at times when resident hot meals are prepared there will be an employee present who holds a Rhode Island Food Manager Certification on the premises. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The Director of Dietary Services will ensure that employees who prepare hot meals will have an active certification as a Rhode Island Food Manager and ensure that all licenses are up to date through monthly audits. Weekly audits of schedules will be completed to ensure compliance with the plan of correction.	

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S 510	Continued From page 9 member on the premises who holds a Rhode Island Food Manager Certification: -02/05/2022 -02/06/2022 -02/13/2022 -02/19/2022 -02/20/2022 -02/28/2022 -03/05/2022 -03/06/2022 During an interview on 03/10/2022 at approximately 4:15 PM, the Administrator acknowledged Staff G,H, and I's certifications are expired and resident hot meals are prepared, at times, without an employee who holds a Rhode Island Food Manager Certification on the premises.	S 510	**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Director of Dietary Services will ensure that a food safety staff member is scheduled at all times when hot meals are prepared. Weekly audits of schedules will be completed to ensure compliance is met for 6 months. Two additional employees will be trained in order to be certified as a Rhode Island Food Manager within the next 6 months.	
S 565 DSP 4/15/22	Residential Care Services 2.4.24(B)(1) Medication Services 2.4.24 (B) (1) Administration of Medications 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. a. The resident or guardian must provide written authorization for the residence to provide administration of medications. b. Medications shall be administered in	S 565	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The finding of these audits will be monitored by the Director of Dietary Services and the Human Resource Director to ensure that compliance is met. These audits will be forwarded to the monthly QA interdisciplinary meeting for (6) months or until continued compliance is met with this plan of correction	

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S 565	Continued From page 10 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. c. All medications must be checked against a physician's orders by a licensed nurse, or pharmacist. d. The resident must be identified prior to administration of any medication. 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. f. Injectable medications, including but not limited to insulin, which cannot be self-administered by the resident, must be administered by a licensed nurse. 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). (1) The legal destruction of hypodermic needles, syringes or other such instruments is the responsibility of the last entitled or authorized possessor. (AA) All personnel or residents legally authorized to use disposal syringes and needles, shall destroy them after one (1) use. (BB) Excess and undesired needles, syringes	S 565		

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S 565	Continued From page 11 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. (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. 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. i. Any medication administered by the residence and refused by a resident shall be documented and reported, as appropriate. 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. 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. l. All centrally stored medications shall be maintained in accordance with manufacturer's labeling and administered by authorized	S 565		

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JEANNE JUGAN RESIDENCE	964 MAIN STREET PAWTUCKET, RI 02860

(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 565	Continued From page 12 personnel. This Requirement is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined the residence failed to ensure that medications were in the original pharmacy-dispensed container with proper label and directions attached, administered in accordance with written orders of a physician, stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access for the singular medication cart. Findings are as follows: During surveyor observation on 03/10/2022 at approximately 12:05 PM, in the presence of Staff K, Certified Medication Technician/Certified Nursing Assistant the following medications were identified without directions for use: -Bottle of Calcium Carbonate for Resident ID #2 -Bottle of Acetaminophen for Resident ID #2 -Bottle of D 3-50 Cholecalciferol for Resident ID #2 -Bottle of Colace Docusate Sodium for Resident ID #2 -Bottle of Geri-Lanta for Resident ID #3 -Bottle of Vitamin D 25 mcg (microgram) for Resident ID #3 -Bottle of Senna Plus for Resident ID #3 -Bottle of "Senior Tabs" for Resident ID #3	S 565	**S565 RESIDENTIAL CARE SERVICES 2.4.24(B)(1) Medication Services** **2.4.24 (B) (1) Administration of Medication** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Corrective action was taken immediately on 3/11/2022 to ensure that Resident ID #3's Bottle of Aspirin Low Dose, Bottle of Vitamin B-12 1000mcg, Bottle of Polyethylene Glycol, Bottle of Acetaminophen 325mg and Bottle of "Anti-Diarrheal" were all labeled with the Resident's name, date of birth and directions for use as required. In addition, Resident ID #4's Bottle of Acetaminophen was labeled with [redacted] name and directions for use as required. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** An audit of all assisted living residents' medications was completed. All medications found not labeled with the resident's name and directions of use were correctly labeled as required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01346	A. BUILDING: _____ B. WING _____	03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	964 MAIN STREET PAWTUCKET, RI 02860

(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 565	Continued From page 13 -Bottle of Aspirin Low Dose for Resident ID #3 -Bottle of Vitamin B-12 1000 mcg for Resident ID #3 -Bottle of Polyethylene Glycol for Resident ID #3 -Bottle of Acetaminophen 325 mg (milligram) for Resident ID #3 -Bottle of "Anti-Diarrheal" for Resident ID #3 -Bottle of Acetaminophen for Resident ID #4 During an interview on 03/10/2022 at approximately 12:15 PM, Staff K acknowledged that the above medications were not labeled with the directions for use, as required.	S 565	**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** A monthly audit will be conducted to review all medications to ensure that all medications are labeled with the assisted living resident's name and the direction of use, as required for 3-month period to ensure compliance is met. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The finding of these audits will be monitored by the Director of Nursing/designee and submitted to the monthly QA interdisciplinary meeting for (3) months or until continued compliance is met with this plan of correction.	