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 _____	01/03/2024

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 biennial State Licensure survey and a complaint/incident investigation survey (TT0E11, 01/03/2024) was conducted at this residence. Deficiencies were identified relative to the State Licensure survey.	S 003	FACILITIES REGULATION RECEIVED JAN 19 2024	
S 565	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 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	S 565	The following is the Plan of Correction for Brookdale Centre of New England regarding the Statement of Deficiencies from the community biannual survey investigation on January 3, 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.	

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Thomas Raccioppa — TITLE: Executive Director — (X6) DATE: 1-17-24

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S 565	Continued From page 1 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 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	S 565	**2.4.24 (B)(1)) Administration of medications** Outdated medications have been removed from the med carts by the HWD at the time of survey. All residents are potentially at risk for the deficient practice. A comprehensive medication record review will be completed by the Health and Wellness Director and/or designees. This will include a review of current residents' medications and their expiration dates. The Health and Wellness Director and or designee will retrain appropriate clinical staff on Medications & Treatments Unused Medication disposal/return policy.	1/7/24 2/2/24 1/31/24

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S 565	Continued From page 2 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 personnel. This Requirement is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined the residence 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 the 1 of 4 medication carts observed. Findings are as follows: 1. During a surveyor observation of the	S 565	Med cart audit forms will be completed weekly by staff nurses or Certified Medication Technicians and submitted to the Health and Wellness Director or designee. Quarterly Quality Assurance review will be conducted by the HWD and Executive Director to verify compliance. ***Responsible: HWD and/or Executive Director.***	**1/7/24 Ongoing** **3/30/22 Ongoing**

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S 565	Continued From page 3 second-floor medication cart on 12/29/2023 at approximately 10:45 AM in the presence of a Certified Medication Technician (CMT), Staff A, revealed the following: - Metamucil 23.5 oz (ounces, a fiber supplement) bottle, without a resident identifier and directions for use. - Budesonide and Formoterol Fumarate 160-4.5 mcg (microgram, a medication used to treat asthma) inhaler with a manufacturer expiration date of "11/2023." - Budesonide and Formoterol Fumarate 160-4.5 mcg inhaler with a manufacturer expiration date of "10/2023." - Normal Saline nasal spray with a manufacturer expiration date of "July 2023." During an interview immediately following this observation with Staff A, she acknowledged the above-mentioned medications had expired. Additionally, she acknowledged the Metamucil did not have a resident identifier and directions for use. 2. During a surveyor observation of the second-floor medication cart narcotics drawer on 12/29/2023 at approximately 11:15 AM in the presence of a Registered Nurse, Staff B, revealed a bottle of Lorazepam Concentrate 2 MG/ML (milligram/milliliter, a medication used to treat anxiety) with an open date of 5/28/2023. The manufacturer instructions indicate to discard the opened bottle after 90 days. During an interview immediately following this observation with Staff B, she acknowledged the	S 565		

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S 565	Continued From page 4 Lorazepam should have been discarded since it had been opened for greater than 90 days. During an interview on 1/2/2024 at approximately 1:50 PM with the Director of Wellness, she could not provide evidence the above-mentioned medications were stored appropriately, as required.	S 565		
S 940	Limited Health Services License Require 2.6.2.R Specific Requirements 2.6.2 (R) Staff Training- Limited Health Services All employees, including those who will assist residents with personal care receive at least four (4) hours of orientation and training in the areas listed below prior to beginning work alone with a resident receiving limited health services. Staff will be provided no less than two (2) hours of continued education in the following areas at intervals not to exceed twelve (12) months. 1. Pressure ulcer treatment and prevention; 2. Simple wound care including postoperative suture care/removal and stasis ulcer care; 3. Ostomy care including appliance changes for residents with established stomas; 4. Urinary catheter care; 5. Reporting changes in condition; 6. Signs and symptoms of infection(s); and 7. Signs and symptoms of dehydration.	S 940	**2.6.2 (R) Staff Training Limited Health Services** Clinical staff identified as A,B,C,D, and E re- inserviced on Limited Health Services All residents at potential risk for deficient practice. Limited Health Service inservice to be conducted to all clinical staff by the HWD/designee in the following area: *pressure ulcer treatment & prevention, simple wound care, ostomy care, urinary catheter care , reporting changes of condition , signs & symptoms of infection and signs & symptoms of dehydration* upon hire and twice yearly thereafter. QA / Safety committees to review for compliance by HWD, BOM and ED ***Responsible: HWD and/or Executive Director***	1/2/24 **1/31/24** **1/31/24** **Ongoing**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 940	Continued From page 5 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 all employees, including those who will assist residents with personal care receive at least four (4) hours of orientation and training prior to beginning working alone with a resident receiving limited health services. Additionally, the residence failed to ensure that existing staff received on-going trainings at intervals not to exceed twelve (12) months for 4 of 8 sample employees reviewed, Staff C, D, E, and F. Findings are as follows: 1. Record review of Staff C revealed a hire date of 6/23/2022. This employee was hired as a Certified Nursing Assistant (CNA). 2. Record review of Staff D revealed a hire date of 9/8/2023. This employee was hired as a CNA. 3. Record review of Staff E revealed a hire date of 8/25/2017. This employee was hired as a CNA. 4. Record review of Staff F revealed a hire date of 12/17/2021. This employee was hired as a Registered Nurse. Record review failed to reveal evidence that the above-mentioned employees had received all required in-service training related to limited health services in the following areas: 1. Pressure ulcer treatment and prevention; 2. Simple wound care including postoperative suture care/removal and stasis ulcer care; 3. Ostomy care including appliance changes for residents with established stomas;	S 940		

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S 940	Continued From page 6 4. Urinary catheter care; 5. Reporting changes in condition; 6. Signs and symptoms of infection(s); and 7. Signs and symptoms of dehydration. During an interview on 1/2/2024 at approximately 1:55 PM, the Director of Wellness was unable to provide evidence that the above-mentioned employees had received all required in-service trainings relative to limited health services.	S 940		

RI Department of Health

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S 003	Initial Comments An unannounced complaint/incident investigation survey and a biennial State licensure survey (Y5O211, 01/03/2024) was conducted at this residence.	S 003		

Facilities Regulation

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

Thomas Giaccione — Executive Director — 1-17-24