

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/05/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/31/2022
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NAME OF PROVIDER OR SUPPLIER HATTIE IDE CHAFFEE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 200 WAMPANOAG TRAIL EAST PROVIDENCE, RI 02914
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(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) COMPLETION DATE
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F 000	INITIAL COMMENTS A Recertification Survey was conducted at Hattie Ide Chaffee Home from 03/28/2022 through 03/31/2022 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. A State licensure and emergency preparedness surveys were also conducted at this facility. As a result of this survey, deficiencies were identified and noted on the enclosed CMS "Statement of Deficiencies" 25467L.	F 000	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 the POC will be April 30, 2022	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to provide services that meet professional standards of quality relative to following physician orders for 1 out of 3 sample residents, Resident ID #41. Findings are as follows: Review of the facility policy titled, "Skin Care Protocol" dated 3/17/2022 states in part, "...It is the policy of this facility to follow appropriate standards of care as they relate to residents' skin care; identification of those "at risk," ...and appropriate interventions and documentation...The physician and the resident's representative shall be made aware	F 658	As a Plan of Correction (POC) for Tag F 658 a) Resident ID # 41 remains in the facility and is receiving appropriate skin care. Notifications have been made as to his/her condition. b) Residents who reside in the facility who are at risk for skin impairment have the potential to be affected by this finding. We have reviewed their status to ensure that they are receiving care according to professional standards. We have made corrections if needed. c) We have provided competency education for the nurses regarding the need for follow through, including notifications and obtaining treatment orders when any changes in skin condition is identified. We have emphasized the importance of shift to shift communication related to skin issues. We use our morning clinical meeting to ensure that changes in skin conditions are acted upon and notifications are made as needed. During our risk meetings we ensure that any new interventions are being	4/30/2022

RECEIVED
APR 30 2022
QUALITIES REGULATION

4/19/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bary B. Zeltz, PhD</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4/18/2022</i>
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any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 658	<p>Continued From page 1 of...significant changes in the resident's condition..."</p> <p>Record review revealed the resident was admitted to the facility in May of 2020 with diagnoses which include but are not limited to Alzheimer's Disease, dementia, anxiety disorder and acquired absence of right leg above the knee.</p> <p>Record review of a progress note dated 3/26/2022 revealed in part, "...5:57 PM Small open area on coccyx had healed. CNA reporting that it was looking raw again. Ointment applied. Biatain (Non-Adhesive soft foam dressing that absorbs and retains wound secretions) applied. Will pass to next shift as well..."</p> <p>Further record review failed to reveal evidence that the physician was notified of the change in the skin condition or that a physician's order for the treatment was put in place.</p> <p>During a surveyor observation on 3/30/2022 at 8:07 AM of the resident revealed and excoriated (part of the surface of the skin is damaged or removed) area on his/her right buttock.</p> <p>During a surveyor interview on 3/30/2022 with Registered Nurse, Staff A, immediately after the above observation she acknowledged that the resident had an open area on the right buttock. Additionally, she revealed that the physician was not notified of the change in skin condition. She was also unable to provide evidence of a physician's order for treatment.</p> <p>During a surveyor interview on 3/30/2022 at 8:23 AM with the Director of Nursing Services, she</p>	F 658 <i>NR</i> <i>4/1/22</i>	<p>implemented and are effective. Care plans are to be revised when needed. We have developed an audit tool to monitor our progress and the effectiveness of this plan.</p> <p>d) The DNS or designee is responsible for this plan of correction. We will monitor compliance through our Quality Improvement Meetings and review the audits. We will revise the plan as needed to ensure compliance. We will review this issue, no less than three quarters and then reevaluate the frequency of monitoring needed.</p>	

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F 658	Continued From page 2 acknowledged that that the facility initiated a treatment without a physician's order nor was the physician notified of the change in the skin condition.	F 658			