,T OF DEFICIENCIES ,I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415057	A. BUILDING _____ B. WING _____	06/22/2022

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERWOOD OF SCALLOP SHELL AT WAKEFIELD	55 SCALLOP SHELL WAY SOUTH KINGSTOWN, RI 02883

(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
F 000	INITIAL COMMENTS A Recertification Survey was conducted at Elderwood Of Scallop Shell At Wakefield from 06/20/2022 through 06/22/2022 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. Deficiencies were cited as a result of this survey.	F 000	RECEIVED JUL 12 2022 FACILITIES REGULATION **In filing an acceptable plan of correction, we seek to comply with the State survey and certification requirement. However, the filing of the acceptable plan of correction does not constitute an admission that the alleged deficiencies exist.**	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. 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 respiratory care consistent with professional standards of practice for 1 of 1 resident reviewed for oxygen therapy, Resident ID #28. According to Brunner and Sudarth's textbook, Medical and Surgical Nursing, 7th Edition, 1992, p. 524, "as with other medications, oxygen is administered with care, and its effects on each patient are carefully assessed. Oxygen is a drug and except in emergency situations is prescribed by a physician."	F 695	**F 695 – Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)** **Corrective Action** — **6/27/2022** An order for oxygen was obtained on 6/22/22 for Resident ID #28. Resident's (ID #28) oxygen tubing was replaced on 6/22/22 and labeled with date and initials as required per policy. An order to replace oxygen tubing weekly was obtained and added on 6/27/22 for Resident ID #28. MR 7/8/22 **Identification of Other Residents** — **6/22/2022** An audit was conducted to ensure that oxygen orders were in place for all residents receiving oxygen and that orders were in place for oxygen tubing to be replaced weekly. There were no additional residents found to be affected by this tag. **Systematic Changes** — **7/01/2022** All nursing staff will be reeducated on the Oxygen Therapy policy. **Monitoring** — **Ongoing** Facility will monitor regularly for compliance with F 695 regarding the use of oxygen therapy. The audits will be reviewed through the QAPI Committee until such time the Committee feels systemic changes are effective and no negative outcomes are identified. The DON will be responsible.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/11/22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other 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 695	Continued From page 1 Findings are as follows: Review of the facility policy titled "Oxygen Therapy (Concentrator)" dated 3/27/2018, states in part...label oxygen tubing with date and initials." Record review revealed the resident was admitted in May of 2021 with diagnoses including, but not limited to, dementia with behavioral disturbance, and chronic obstructive pulmonary disease (a condition involving constriction of the airways). Surveyor observations on the following dates and times revealed the resident was receiving oxygen therapy at 3 liters via nasal cannula: -6/20/2022 at 9:31 AM and 1:41 PM -6/21/2022 at 8:56 AM and 10:06 AM Additionally, observation of the oxygen tubing failed to reveal evidence of a label indicating date and initials. Record review of the physician orders failed to reveal evidence of an order for oxygen therapy. Further record review failed to reveal evidence of an order to change the oxygen tubing weekly. During a surveyor interview on 6/21/2022 at 2:49 PM with the unit nurse, Staff A, she acknowledged that the resident is currently receiving oxygen at 3 liters, and s/he should have an order for oxygen. Additionally, Staff A was unable to provide evidence of an order for oxygen therapy and an order to change the oxygen tubing weekly.	F 695		

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F 880	Continued From page 2	F 880		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880	**F 880 – Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)** **Corrective Action** **6/21/2022** Equipment used for resident ID #25 during observation was immediately disinfected using the proper wipes available and intended for this purpose. Staff A was reeducated regarding the proper disinfection of non-dedicated equipment. Staff B was reeducated regarding the proper use of PPE and hand hygiene after providing resident care/services and before retrieving or handling clean linens or briefs. **Identification of Other Residents** **6/22/2022** Observational audits were conducted to ensure proper use of PPE, hand hygiene, and disinfection of non-dedicated equipment. There were no additional residents found to be affected by this tag. **Systematic Changes** **07/01/2022** An infection control root cause analysis will be completed and QAPI action plan developed with a focus on surveyor observations. All staff will be reeducated on disinfecting of non-dedicated equipment, handwashing technique, and proper use of PPE. Infection control policies and procedures will be reviewed and revised (as needed) no less than every two weeks for the next six months by the medical director, administrator, director of nursing, and facility's ICP. Any infection control policy revisions will be reeducated to the staff within 5 days of revision. **Monitoring** **Ongoing** Facility will monitor regularly for compliance with F880 regarding the disinfection of non-dedicated equipment, hand hygiene, and proper use of PPE. The audits will be reviewed through the QAPI Committee until such time the Committee feels systemic changes are effective and no negative outcomes are identified. The DON will be responsible.	

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7/12/22

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F 880	Continued From page 3 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. 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 implement infection control measures to provide a sanitary environment and prevent the transmission of communicable diseases and infections relative to the proper use of Personal Protective Equipment (PPE), hand hygiene, and disinfection of non-dedicated equipment.	F 880		

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F 880	Continued From page 4 Findings are as follows: 1. Record review of the facility's policy titled, "Cleaning-Disinfecting of Non-Critical Care Items" last modified on 4/4/2022 states in part, "...This policy applies to all staff who use, handle or clean non-critical reusable equipment and items for resident/patient use...To reduce the transmission of micro-organisms due to contaminated non-critical reusable equipment/items for resident/patient use...Disinfection: The inactivation of disease producing organisms...Disinfectants are used on inanimate objects, non-critical care items and most environmental surfaces...Non-Critical Items: Those items that either touch only intact skin but not mucous membranes... POLICY: Non-Critical Patient Care Devices/Equipment Key Points... 2. Cleaning and disinfecting of reusable equipment/items which have been in direct contact with a patient should be done before use in the care of another patient... Clean and disinfect non-critical reusable items. ...2. Use appropriate...facility approved disinfectant according to product directions. 3. Allow all cleaned and disinfected non-critical reusable items to air-dry prior to use in the care of another patient, following manufacturer's contact time [the amount of time a disinfectant is required to remain wet on a surface, without being wiped away or disturbed, to effectively kill bacteria]	F 880		

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F 880	Continued From page 5 recommendation..." During a surveyor observation on 6/21/2022 at 9:05 AM revealed Staff A exiting Resident ID #25's room, obtained Purell hand sanitizer foam from the wall dispenser to perform hand hygiene and then continued to use her hands to apply the Purell foam sanitizer to the infrared thermometer and Pulse Oximeter, which were used in that resident's room. During a surveyor interview immediately following the observation with Staff A, she revealed that she usually uses Purell hand sanitizer to disinfect the equipment, not disinfectant wipes. During a surveyor interview on 6/21/2022 at approximately 2:30 PM with the Director of Nursing Services (DNS), she acknowledged that Staff A should not be using Purell hand sanitizer to disinfect medical equipment, and she would expect staff to disinfect the equipment using disinfectant wipes, such as Clorox or Sani clothes. 2. Record review of the facility's policy titled, "Handwashing Technique" last modified on 3/19/2019 states in part, "...All staff will be expected to use a specified hand-washing technique, which is considered one of the prime methods for controlling the spread of communicable infection, diseases or agents within this facility...Staff are instructed to use the proper hand-washing techniques under the following circumstances: ...f. After contact with contaminated linen, object or article, or equipment g. Before, during (if applicable), and after providing resident care/services...k. Before handling any item that is to be maintained in a	F 880		

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F 880	Continued From page 6 "clean" state, such as linens, dishes, etc..." During surveyor observation on 6/21/2022 at 2:23 PM of Nursing Assistant (NA), Staff B, she was observed exiting Resident ID #28's room wearing gloves and walked across the hallway to the linen closet to retrieve a brief for the resident. Staff B returned to the resident's room, without removing her gloves and/or performing hand hygiene. Additionally, Staff B was observed a few minutes later, exiting the same resident's room wearing gloves, she then walked across the hall to the linen closet to retrieve an item without removing her gloves and/or performing hand hygiene and re-entered the resident's room During a surveyor interview on 6/21/2022 at 2:30 PM with Staff B, she acknowledged that she assisted the other NA to transfer and retrieve his/her brief and linen. During a surveyor interview on 6/21/2022 at 3:45 PM with the DNS, she revealed staff are supposed to remove their gloves and wash their hands when exiting a resident's room and before retrieving an item from the clean linen room.	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced	F 919	**F 919 – Resident Call System CFR(s): 483.9(g)(2)** **Corrective Action** **6/21/2022** Resident ID #4's call light was immediately placed within reach following the surveyor observation and interview with Staff C. **Identification of Other Residents** **6/22/2022** A call light audit was completed to ensure call bells were in reach for all residents. There were no additional residents found to be affected by this tag. **Systematic Changes** **7/01/2022** All staff will be reeducated on the facility's Call Light/Call Bell policy.	

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F 919	Continued From page 7 by: Based on surveyor observation, record review, and staff and resident interview, it has been determined that the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for 1 of 5 residents reviewed who at risk for falls, Resident ID #4. Findings are as follows: Record review of the facility's policy titled "Call Light\Call Bell\Nurse Call System" revealed, "1. a)...Nursing Assistant is responsible for ensuring the call light signal apparatus is within reach of residents who remain in their rooms..." Record review revealed the resident was admitted to the facility in February of 2019 with diagnoses including, but not limited to, dementia, post-polio syndrome (muscular weakness from polio virus infection), and osteoarthritis. Review of the resident's quarterly MORSE Fall Scale Assessment (method of assessing a patient's likelihood of falling) dated 3/25/2022 indicates that s/he is at high risk of falling. Record review of the quarterly MDS (minimum data set) assessment dated 3/24/2022 revealed the resident requires extensive assistance when moving between location in his/her room. Review of the resident's care plan initiated on 2/6/2019 with a revise date of 3/28/2022 revealed a focus of "SAFETY: I am at high high risk for falls related to Hx [history] of falls, instability,	F 919	**Monitoring** **Ongoing** Facility will monitor regularly for compliance with F919 regarding the call light/call bell policy. The audits will be reviewed through the QAPI Committee until such time the Committee feels systemic changes are effective and no negative outcomes are identified. The DON will be responsible. MR 7/12/22	

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F 919	Continued From page 8 weakness, post polio syndrome, WC [wheelchair] bound." Further review of the resident's care plan revealed an intervention initiated on 2/6/2019 to "keep call light within reach..." During a surveyor interview with the resident on 6/20/2022 at 9:41 AM, the resident revealed that s/he cannot reach the call light because "they never transfer it from the rail closer to me." Immediately following the interview, an observation of the resident revealed the call light hanging on the left bedside rail closest to the head of the bed while the resident was sitting in the wheelchair located at the foot of the bed and was unable to access the call light. Additional surveyor observations revealed the resident was unable to reach his/her call light on 6/21/2022 at 10:08 AM, 1:45 PM, 2:19 PM, and 3:38 PM. During a surveyor interview on 6/21/2022 at 3:43 PM with the nursing assistant Staff C, she revealed that the call light is supposed to be placed where the resident can reach it. Additionally, she moved the call light from the resident's side rail to the foot of the bed where the resident can reach it. During a surveyor interview with the Director of Nursing Services on 6/21/2022 at 4:02 PM, she acknowledged that the call light should be placed where it is easily accessible to the resident.	F 919		