

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

PRINTED: 04/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/07/2022
NAME OF PROVIDER OR SUPPLIER AVALON NURSING HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE 67 STOKES STREET WARWICK, RI 02889	
(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 off hour & Complaints Investigation Survey, ACTS Reference Number 83474, was conducted at this facility from 04/03/2022 to 04/07/2022 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. Census/bed count: 29/31	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-	F 655		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

[Signature]

4/27/22

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.

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

PRINTED: 04/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/07/2022
NAME OF PROVIDER OR SUPPLIER AVALON NURSING HOME INC		STREET ADDRESS, CITY, STATE, ZIP CODE 57 STOKES STREET WARWICK, RI 02889		
(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 655	<p>Continued From page 1</p> <p>(i) Is developed within 48 hours of the resident's admission.</p> <p>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident.</p> <p>(ii) A summary of the resident's medications and dietary instructions.</p> <p>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.</p> <p>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it has been determined that the facility failed to develop and implement a baseline care plan within 48 hours of admission, that includes the instructions needed to provide effective and person-centered care, for 2 of 2 residents reviewed for baseline care plans, Resident ID #s 32 and 231.</p> <p>Findings are as follows:</p> <p>1. Review of the medical record for Resident ID #32 revealed that s/he was admitted to the facility on 3/1/2022 with diagnoses including, but not limited to unspecified dementia without behavioral disturbance and anxiety. Additionally, it was revealed that the resident has a history of wandering.</p> <p>Review of a progress note dated 3/8/2022</p>	F 655		

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

PRINTED: 04/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/07/2022
NAME OF PROVIDER OR SUPPLIER AVALON NURSING HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE 67 STOKES STREET WARWICK, RI 02889		
(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 655	Continued From page 2 revealed in part, "...During change of shift report resident eloped from the building, with the assistance of multiple staff members [s/he] was redirected back inside..." Further review of the record failed to reveal evidence that a baseline care plan was created. 2. Record review for Resident ID #231 revealed the resident was admitted to the facility on 3/22/2022 with diagnoses including, but not limited to, dementia, depression, and psychotic disorder with delusions. Additional review revealed that s/he has a history of elopement attempts prior to her/his admission to the facility. Further record review failed to reveal evidence of a baseline care plan for the resident. During a surveyor interview on 4/6/2022 at 9:22 AM with the Director of Nursing, she was unable to provide evidence that a baseline care plan was developed for the above-mentioned residents to include instructions needed to provide effective and person-centered interventions to prevent elopement.	F 655			
F 805 SS=E	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that	F 805			

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

PRINTED: 04/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/07/2022
NAME OF PROVIDER OR SUPPLIER AVALON NURSING HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE 57 STOKES STREET WARWICK, RI 02889		
(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 805	<p>Continued From page 3</p> <p>the facility failed to assure that residents receive and consume food in the appropriate form for 4 of 12 residents observed, Resident ID #'s 8, 22, 30 and 231.</p> <p>Findings are as follows:</p> <p>Record review of the facility menu for the week of 4/3/2022 revealed the following:</p> <p>Ground Diets Noon Meal:</p> <ul style="list-style-type: none"> - 4/4/2022, ground bread veal patty/gravy - 4/6/2022, ground hamburger <p>Additional record review of the facility diet manual titled, "The New England Diet Manual", revealed in part, "...Ground Texture Foods Allowed...Ground meats and poultry..., foods to avoid...whole meats and poultry, crunchy with breading and tatar tots..."</p> <p>Review of the record for Resident ID #'s 231 and 30 revealed physician orders for a ground meat only diet.</p> <p>During surveyor observation on 4/4/2022 at 12:30 PM Resident ID #'s 231 and 30 were observed to have breaded veal patty cut in pieces, not in ground form per the physician orders, menu and the diet description of a ground diet texture.</p> <p>Record review for Resident ID #8 revealed a physician's order for a ground diet.</p> <p>During surveyor observation on 4/4/2022 at approximately 11:40 AM, it was revealed that s/he received a breaded veal patty cut up.</p>	F 805			

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

PRINTED: 04/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/07/2022
NAME OF PROVIDER OR SUPPLIER AVALON NURSING HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE 57 STOKES STREET WARWICK, RI 02889		
(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 805	Continued From page 4 Record review of Resident ID # 22 revealed a physician order for a ground diet. During a surveyor observation on 4/7/2022 at approximately 11:40 AM, it was revealed that s/he received hamburger patty on a bun and tater tots. During an interview with the Administrator on 4/7/2022 at 2:00 PM, he was unable to provide evidence that the residents received and consumed food in the appropriate form.	F 805			
F 812 SS=F	Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(l)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(l)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that	F 812			

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

PRINTED: 04/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/07/2022
NAME OF PROVIDER OR SUPPLIER AVALON NURSING HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE 67 STOKES STREET WARWICK, RI 02889		
(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 B12	<p>Continued From page 5</p> <p>the facility failed to ensure that food is stored, prepared, distributed, and served in accordance with professional standards for food service safety relative to the main kitchen.</p> <p>Findings are as follows:</p> <p>1)Record review of the facility policy titled, "Food Storage" states in part, "...all foods should be covered, labeled and dated with product name and use by date..."</p> <p>During the initial tour of the main kitchen on 4/3/2022 at approximately 8:35 AM, revealed the reach in freezer unit on the 1st floor kitchen area and the dry storage area with the following items unlabeled and not dated:</p> <ul style="list-style-type: none"> - frozen omelets - frozen chicken patties -frozen sausage patties - mixed vegetable blend - 2 storage containers with cereal - unknown white package in beverage refrigerator - a 9 x13 container sitting at room temperature containing poultry <p>Additional surveyor observation of the freezer units located on the ground floor on 4/6/2022 at approximately 9:17 AM revealed the following:</p> <ul style="list-style-type: none"> - a container, approximately 9"x13" in size, without a product identifier or date 	F 812			

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

PRINTED: 04/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/07/2022
NAME OF PROVIDER OR SUPPLIER AVALON NURSING HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE 57 STOKES STREET WARWICK, RI 02889		
(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 812	<p>Continued From page 6</p> <ul style="list-style-type: none"> - ground beef and pot roast without use by dates or pull dates of the product - a manufacturer's container of onion dip that had cut up strawberries stored inside <p>2) Record review of the policy titled, "Food Storage", states in part, "...Temperatures for refrigerators should be checked at least two times a day...Temperatures for the freezer should be checked at least two times a day..."</p> <p>Record review of the refrigerator and freezer logs from 4/3/2022 through 4/6/2022 revealed the temperatures were recorded once daily.</p> <p>3)Record review of policy titled, 'Dish machine Temperature Log', states in part, "...Dishwashing staff will monitor and record dish machine temperatures to assure proper sanitizing of dishes...staff will be trained to record dish machine temperatures for the wash and rinse cycle at each meal..."</p> <p>Surveyor observation of the dish machine revealed a chlorine-based chemical was used for sanitizing dishes and not a hot water rinse.</p> <p>Record review of dish machine log revealed sanitizing checks were completed once daily from 4/3/2022 through 4/6/2022.</p> <p>Surveyor observation during lunch meals from 4/4/2022 through 4/6/2022 revealed the dietary aide, utilizing a gloved hand that touched the handles of the lakeside cart, place ice cubes from ice cube trays in resident glasses for beverages.</p>	F 812			

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

PRINTED: 04/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/07/2022
NAME OF PROVIDER OR SUPPLIER AVALON NURSING HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE 57 STOKES STREET WARWICK, RI 02889		
(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 812	Continued From page 7 An additional surveyor observation during lunch preparation on 4/3/2022 through 4/6/2022 revealed the dietary aide and cook failed to wash their hands before donning gloves after leaving the main kitchen. During an interview with the Administrator on 4/6/2022 at approximately 12:30 PM, he was unacknowledged the above observations.	F 812			

PRINTED: 04/14/2022
FORM APPROVED

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: LTC00446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/07/2022
--	--	---	--

NAME OF PROVIDER OR SUPPLIER AVALON NURSING HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 57 STOKES STREET WARWICK, RI 02889
---	--

(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
M 210	<p>PERSONNEL 1.14.4.A. Employee Immunization & Screening</p> <p>1.14.4.A. Nursing Facilities are required to adopt, at a minimum, the standards of immunization and communicable disease testing and standards for health screening in accordance with the rules and regulations pertaining to Immunization, Testing, and Health Screening for Health Care Workers (Part 20-15-7 of this Title).</p> <p>This Requirement is not met as evidenced by: Based on personnel record review and staff interview, it was determined that the facility failed to obtain evidence of immunity in accordance with the Rules and Regulations Pertaining to Immunization, Testing, and Health Screening for Health Care Workers (R23-17-HCW) promulgated by the Department of Health, for 3 of 8 employees, Staff ID's G, I and J.</p> <p>Findings are as follows:</p> <p>The Rules and Regulations Pertaining to Immunization, Testing, and Health Screening for Health Care Workers (R23-17-HCW) states, in part:</p> <p>Per the Rules and Regulations Pertaining to Immunization, Testing, and Health Screening for Health Care Workers (R20-15-7) which states in part:</p> <p>"7.6 Minimum Standards for Immunization and Communicable Disease Testing for Health Care Workers</p> <p>A. A pre-employment health screening shall be required for each health care worker involved in direct patient contact. Acceptable evidence shall</p>	M 210		

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

RECEIVED AT: RECEIVED: 2022-04-27 09:01:31 (GMT -05:00)

PRINTED: 04/14/2022
FORM APPROVED

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: LTC00446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/07/2022
NAME OF PROVIDER OR SUPPLIER AVALON NURSING HOME INC		STREET ADDRESS, CITY, STATE, ZIP CODE 57 STOKES STREET WARWICK, RI 02889		
(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
M 210	<p>Continued From page 1</p> <p>be provided by the health care worker that testing and/or immunizations for the communicable diseases listed in these Regulations for pre-employment health screening have been completed.</p> <p>B. The health care facility shall document, in written or electronic form, that said acceptable evidence has been provided by the health care worker and validated by the practitioner as being acceptable in accordance with §7.7 of these Regulations. Copies of said acceptable evidence shall be maintained in the health care worker's file...</p> <p>7.6.1 Immunization and Testing Requirements</p> <p>A. In accordance with the guidelines set forth in § 7.3(C) of this Part of these Regulations, evidence of immunity is required for all health care workers (except for health care workers who receive a medical exemption) against...</p> <p>4. Annual Seasonal Influenza:</p> <p>a. Annual influenza vaccination is required for all health care workers as defined in §7.4, subject to 7.8 (H) when there is insufficient vaccine supply as determined by the Department.</p> <p>b. Each health care facility shall develop a specific plan to require annual influenza vaccination of all health care workers in a timely manner in keeping with ACIP [Advisory Committee on Immunization Practices] guidelines, and at no cost to the health care worker.</p> <p>c. Each health care facility shall maintain an active surveillance program to track and record influenza vaccination levels among health care</p>	M 210		

PRINTED: 04/14/2022
FORM APPROVED

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: LTC00448	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/07/2022
NAME OF PROVIDER OR SUPPLIER AVALON NURSING HOME INC		STREET ADDRESS, CITY, STATE, ZIP CODE 57 STOKES STREET WARWICK, RI 02889		
(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
M 210	Continued From page 2 workers, including vaccinations obtained outside of the formal health care facility program ... 7.8 Medical Exemption and Influenza Vaccination Refusal D. Any health care worker may refuse the annual seasonal influenza vaccination requirements described in these regulations; provided, however, that he or she provides proper annual written notice of such refusal prior to December 15 of each year to each health care facility in or at which he or she is employed..." Record review of the personnel files, relative to immunizations, revealed the following: 1. Employee G, hired on 1/28/2022, lacked evidence of an annual seasonal influenza vaccination or declination thereof. 2. Employee I, hired on 7/26/2021, lacked evidence of an annual seasonal influenza vaccination or declination thereof. 3. Employee J, hired on 10/29/2021, lacked evidence of an annual seasonal influenza vaccination or declination thereof. During surveyor interview with the Director of Nursing on 4/7/2022 at approximately 11:30 AM, she was unable to provide evidence that the above mentioned employees were either vaccinated or signed a form declining vaccination.	M 210		
M 220	PERSONNEL 1.14.5.A. Personnel Records 1.14.5.A. Personnel records shall be maintained for each employee, shall be available at all times for inspection and shall include no less than the	M 220		

PRINTED: 04/14/2022
FORM APPROVED

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: LTC00446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/07/2022
NAME OF PROVIDER OR SUPPLIER AVALON NURSING HOME INC		STREET ADDRESS, CITY, STATE, ZIP CODE 57 STOKES STREET WARWICK, RI 02889		
(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
M 220	<p>Continued From page 3</p> <p>following:</p> <ol style="list-style-type: none"> 1. Current and background information covering qualifications for employment; 2. Records of completion of required orientation training and In-service educational programs, as indicated in § 1.14.6 of this Part; 3. Records of all required health examinations which shall be kept confidential and in accordance with R.I. Gen. Laws Chapter 5-37.3; 4. Evidence of current registration, certification or licensure of personnel subject to statutory regulation; 5. Annual work performance evaluation records; and 6. Evidence of authorization to administer medications for licensed personnel in accordance with § 1.16.10(A) of this Part. <p>This Requirement is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to obtain evidence of active licensing in accordance with the Rules and Regulations 216-RICR-40-05-22 Nursing Assistants, Medication Aides, and the Approval of Nursing Assistant and Medication Aide Training Programs pertaining to licensing of Nursing Assistants promulgated by the Department of Health, for 1 of 8 employees reviewed, Staff J.</p> <p>Findings are as follows:</p> <p>Record review revealed Staff J was hired on 10/29/2021 and the personnel file lacked evidence of a current Nursing Assistant (NA) license.</p> <p>During surveyor interview with the Director of Nursing, on 4/7/2022 at approximately 11:30 AM,</p>	M 220		

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: LTC00446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/07/2022
NAME OF PROVIDER OR SUPPLIER AVALON NURSING HOME INC		STREET ADDRESS, CITY, STATE, ZIP CODE 57 STOKES STREET WARWICK, RI 02889		
(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
M 220	Continued From page 4 she was unable to provide evidence of a current license for Staff J.	M 220		
M 225	PERSONNEL 1.14.6.A. In-Service Education 1.14.6.A. An in-service educational program shall be conducted on an ongoing basis, which shall include an orientation program for new personnel and a program for the development and improvement of skills of all personnel. The in-service program shall be geared to the needs of the elderly, physically disabled, and individuals with dementia, and shall include annual programs on but not limited to: 1. Prevention and control of infection; 2. Food services and sanitation, 3. Emergency preparedness, fire prevention and safety; 4. Confidentiality of resident information; 5. Rights of residents, resident-directed care, and person-centered care; and 6. Any other area related to resident care or services routinely provided at the nursing. a. Provision shall be made for written documentation of programs, including attendance. Flexible program schedules shall be formulated at least two (2) months in advance. b. In addition to any state or federal training requirements pertaining to long term care facilities, or training deemed appropriate by the nursing, each designated universal worker shall maintain a current certification as a Manager Certified in Food Safety pursuant to the rules and regulations for Certification of Managers in Food Safety (Part 50-10-2 of this Title). This Requirement is not met as evidenced by: Based on record review and staff interview, it has	M 225		

PRINTED: 04/14/2022
FORM APPROVED

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: LTC00446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/07/2022
NAME OF PROVIDER OR SUPPLIER AVALON NURSING HOME INC		STREET ADDRESS, CITY, STATE, ZIP CODE 57 STOKES STREET WARWICK, RI 02889		
(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
M 225	<p>Continued From page 5</p> <p>been determined that the facility failed to ensure the orientation program for new personnel and the annual in-service program contained all necessary components for all staff reviewed, Staff ID's A- GG, the Director of Nursing Services, and the Administrator.</p> <p>Findings are as follows:</p> <p>Record review failed to reveal evidence of an in-service training relative to "Food services and sanitation" per the regulation, for the year of 2021.</p> <p>Further review of the annual in-service educations failed to reveal evidence of the following trainings relative to:</p> <ul style="list-style-type: none"> - Infection control for 8 employees - Fire safety for 8 employees - Confidentiality of resident information for 7 employees - Rights of residents for 8 employees <p>During an interview with the Director of Nursing on 4/6/2022 at approximately 11:00 AM, she was unable to provide evidence of the mandatory education for the above-mentioned employees. Additionally, she was unable to provide a facility policy relative to staff education.</p>	M 225		

F655

- 1. All resident's care plans are up to date
- 2. Future resident's care plans will be in effect within 48 hours
- 3. MDS Coordinator will ensure baseline care plan's will be done within two days of admit
- 4. DNS will oversee MDS Coordinator

MR
4/29/22

Completed 4/11/22

F805

- 1. All residents are receiving proper diets
- 2. Dietary staff will follow recipe manual to ensure that residents will receive proper diets
- 3. Food Service Manager will oversee the dietary department to ensure that proper diets are being given
- 4. Dietary consultant will oversee the Food Service Manager

MR
4/29/22

Completed 4/11/22

F812

- 1. Labels were purchased to ensure proper labeling. A new temperature log template will be used which shows twice a day temperature taking (enclosed). The sanitizer log has the ability to be taken three times daily (enclosed).
- 2. Dietary staff will make sure these are done going forward
- 3. Food Service Manager will oversee the dietary department to ensure these are completed
- 4. Administrator will oversee the Food Service Manager

MR
4/29/22

Completed 4/11/22

M210

- 1. All personnel records will have all required immunizations.
- 2. Enclosed is a new form that will be used on hire to capture all immunizations including Influenza.
- 3. DNS will ensure all new hires records are complete using the new checklist
- 4. Administrator will oversee the DNS.

ML
4/29/22

Completed 4/11/22

M220

- 1. DNS will ensure that all new hires have appropriate documentation of licensure
- 2. ADNS will check all employee licensing quarterly.
- 3. DNS will oversee ADNS
- 4. Administrator will oversee DNS.

ML / *21/29/22*

Completed 4/20/22

M225

- 1. In-servicing of employees is being overhauled to make sure that all employees are being In-serviced according to regulation.
- 2. DNS has created a new checklist that all employees will receive on hire and annually
- 3. Enclosed please see the new checklist
- 4. Administrator to oversee the DNS

Completed 4/11/22

ML
4/29/22