RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LTC00774	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SAKONNET BAY	1215 MAIN ROAD TIVERTON, RI 02878

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M 0	INITIAL COMMENTS The annual State licensure and a complaint investigation (LZ9611, 03/17/2022) survey were conducted at this facility. Deficiencies were identified.	M 0	Enclosed is the Plan of Correction for Brookdale Sakonnet Bay in response to the Statement of Deficiencies. While this document is being submitted as confirmation of the facility's on-going efforts to comply with all statutory and regulatory requirements, it should not be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies.	
M 100	ORGANIZATION AND MANAGEMENT 1.13.2.E. Quality Improvement Program 1.13.2.E. Each nursing facility shall establish a written quality improvement plan that shall be reviewed by the Department during the nursing facility ' s annual survey and that includes: 1. Program objectives; 2. Oversight responsibility (e.g., reports to the governing body, QI records); 3. Nursing facility-wide scope; 4. Involvement of all resident care disciplines/services; 5. Includes methods to identify, evaluate, and correct identified problems; 6. Provides criteria to monitor nursing care and services, including, but not limited to: a. Medication administration; b. Prevention and treatment of decubitus ulcers; c. Dehydration, and nutritional status and weight loss or gain; d. Accidents, injuries and unexpected deaths; 7. Changes in mental or psychological status; 8. Resident and/or Family Council grievances; 9. Plans of correction developed in response to licensing agency ' s inspection reports, and 10. Any other data appropriate to monitor resident ' s quality of care and quality of life. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined the facility failed to have a	M 100 MR 4/19/22	M100 Brookdale Sakonnet Bay has established a written quality improvement plan. This quality Improvement plan includes all required components including: program objectives; quality improvement records; nursing facility-wide scope, involvement of all resident care services, methods to identify, evaluate, and correct problems; provides criteria to monitor all nursing care and services; changes in mental and psychological statuses; resident and family counsel grievances; plans of correction, and any other data appropriate to monitor resident's quality of care and quality of life. 1. Corrective actions taken for residents found to have been affected by the deficient practice: No residents were identified or found to have been affected by this practice. This facility has taken corrective action to address this deficiency by presenting the written Quality Assurance Performance Improvement (QAPI) Plan. On 4/15/22 during the scheduled QAPI Committee meeting 5-/-22	

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tom Smith TITLE: Exec Dir (X6) DATE: 4/17/22

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M 100	Continued From page 1 written quality improvement plan. Findings are as follows: Record review revealed the facility failed to have a written quality improvement plan which included all required components. During interviews on 03/17/2022 at approximately 11:45 AM and 12:15 PM, the Director of Clinical Services and the Administrator were unable to produce evidence of a written quality improvement plan.	M 100	the Executive Director will present the QAPI plan to the members of the QAPI Committee. 2. Corrective actions taken to identify other residents having the same potential to be affected by the same deficient practice: No other residents were affected by this practice. A written Quality Assurance Performance Improvement plan will be presented by the Executive Director to the QAPI Committee on 4/15/22.	
M 105	ORGANIZATION AND LEADERSHIP 1.13.2.F. Quality Improvement Program 1.13.2.F. All resident care services, including services rendered by a contractor, shall be evaluated. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the quality improvement committee failed to evaluate all resident care services, including services rendered by a contractor. Findings are as follows: Record review of the facility's quality improvement documentation failed to demonstrate evaluation of the following contracted services: -Physical therapy -Occupational therapy	M 105 ur 4/14/22	3. Measures put into place and systemic changes made to ensure that the deficient practice does not recur: Systematic changes and additional corrective action includes an annual review and revision of the QAPI Plan by the Executive Director or designee. Review and any revision to be done in collaboration with the QAPI Committee in July 2022 and then annually thereafter. 4. How the corrective action will be monitored to ensure the deficient practice will not reoccur; what QA program will be put into place: The stated corrective action, including survey plans of correction, will be monitored by the Executive Director or designee as a component of the QAPI program. Compliance by 5/1/22 M105	

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M 105	Continued From page 2 -Speech therapy -Hospice care -Psychiatric services -Services provided by the registered dietitian (RD) During an interview on 03/17/2022 at approximately 11:30 AM, the Director of Clinical Services acknowledged contracted resident care services were not evaluated by the quality improvement committee.	M 105	Brookdale Sakonnet Bay evaluates all resident care services, including those services rendered by: physical therapy; occupational therapy; speech therapy; hospice care; psychiatric services, and services provided by the registered dietician. 1. Corrective actions taken for residents found to have been affected by the deficient practice: No residents were identified or found to have been affected by this practice. This facility has taken corrective action to address this deficiency by incorporating evaluations of contracted services including: PT, OT, ST, Hospice, Psychiatric services, and services provided by the RD, as part of the QAPI meeting. These evaluations will be completed during the 4/15/22 QAPI Committee Meeting. 2. Corrective actions taken to identify other residents having the same potential to be affected by the same deficient practice: No other residents were affected by this practice. 3. Measures put into place and systemic changes made to ensure that the deficient practice does not recur: In order to prevent re-occurrences, the above mentioned contracted services shall attend and or prepare service reports for the Executive Director or designee. Contract service reports	
M 110	ORGANIZATION AND MANAGEMENT 1.13.2.G. Quality Improvement Program 1.13.2.G. The nursing facility shall take and document appropriate remedial action to address problems identified through the quality improvement program. The nursing facility administrator shall take appropriate remedial actions based on the recommendations of the nursing facility ' s quality improvement committee. The outcome(s) of the remedial action shall be documented and submitted to the governing body for their consideration. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the facility failed to document appropriate remedial action to address problems identified through the quality improvement program. Findings are as follows:	M 110		

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M 110	Continued From page 3 Record review of the facility's quality improvement documentation failed to reveal documentation of the remedial action taken to address the following: -Mental and psychological status changes in residents -Resident and Family Council grievances -Corrective actions in response to Rhode Island Department of Health (RIDOH) surveys During an interview on 03/17/2022 at approximately 11:35 AM, the Director of Clinical Services acknowledged the quality improvement committee did not document remedial action relative to the above areas.	M 110	shall be reviewed by the QAPI committee at least quarterly. 4. How the corrective action will be monitored to ensure the deficient practice will not reoccur; what QA program will be put into place: The stated corrective action, including evaluation of contract services, will be monitored by the Executive Director or designee as a component of the QAPI program. Compliance by 5/1/22 M110 Brookdale Sakonnet Bay takes and documents appropriate remedial action to address problems identified through the QAPI program including: mental and psychological status changes in residents; resident and family council grievances; and corrective actions in response to RIDOH surveys. 1. Corrective actions taken for residents found to have been affected by the deficient practice: On 4/13/22 the social worker reviewed the family and resident grievances for March for completion. On 4/13/22 the social worker reviewed the psychotropic monthly medication review form for altered behaviors for the month of March. There were no RIDOH survey deficiencies to review in QAPI.	
M 215	PERSONNEL 1.14.4.B. Employee Immunization & Screening 1.14.4.B. Nursing Facilities are required to obtain evidence of immunity for all health care workers 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) promulgated by the Department of Health. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined that the facility failed to obtain evidence of immunity for all health care workers in accordance with the Rules and Regulations Pertaining to Immunization, Testing, and Health Screening for Health Care Workers (Part 20-15-7	M 215		

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M 215	Continued From page 4 of this Title) promulgated by the Department of Health for 3 of 6 sample staff reviewed, Staff ID's B, E, and F. Findings are as follows: Per the Rules and Regulations Pertaining to Immunization, Testing, and Health Screening for Health Care Workers (R20-15-7) which states in part: "...7.6.1 Immunization and Testing Requirements: 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: 3. Tetanus, Diphtheria, and Pertussis (Whooping Cough): a. Pre-employment: One (1) single dose of Tdap (tetanus-diphtheria-pertussis) vaccine is required for all health care workers who have not previously received a dose of Tdap vaccine ... 4. Annual Seasonal Influenza: 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. 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 guidelines, and at no cost to the health care worker.	M 215 MR 4/19/22 MR 4/19/22	2. Corrective actions taken to identify other residents having the same potential to be affected by the same deficient practice: On 4/13/22 the social worker reviewed the family and resident grievances for March for completion. On 4/13/22 the social worker reviewed the psychotropic monthly medication review form for altered behaviors for the month of March. There were no RIDOH survey deficiencies to review in QAPI. 3. Measures put into place and systemic changes made to ensure that the deficient practice does not recur: On 4/13/22 the Executive Director re-educated the social worker on the process of resident and family grievances, mental and behavioral changes, and plans of correction during QAPI meetings. In order to prevent re-occurrences, the social worker will log family and resident grievances and discuss during the daily standup with the Interdisciplinary Team (IDT). The social worker will update the psychotropic medication review form including but not limited to behaviors. The IDT will review RIDOH survey deficiencies and plans of correction in the monthly QAPI meeting.	

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M 215	Continued From page 5 c. Each health care facility shall maintain an active surveillance program to track and record influenza vaccination levels among health care workers, including vaccinations obtained outside of the formal health care facility program... 5. Tuberculosis (TB): (a) Pre-employment. Evidence that the health care worker is free of active tuberculosis based upon the results of a negative two-step tuberculin skin test shall be required. (1) If documented evidence is provided by the health care worker that a two-step tuberculin skin test, performed within the most recent twelve (12) months prior to hire, was negative, the requirements of this section shall be met. For health care workers who can present documentation of serial tuberculin testing with negative results in the prior two (2) years (or more), a single baseline negative tuberculin test is sufficient evidence of absence of TB infection. (2) A negative FDA-approved blood assay for Mycobacterium tuberculosis (BAMT) may be used instead of a two-step tuberculin skin test. If the baseline BAMT is positive, screening should proceed as indicated below for positive PPD. (3) Documentation shall include date and result of the tuberculin skin test (PPD), and reaction size in millimeters or an actual copy of the laboratory test result from a BAMT. (4) If the PPD test or BAMT is positive, consistent with the most current Centers for Disease Control and Prevention (CDC) guidance, or a previous one is known to have been positive, a physician's or other licensed practitioner's (acting within	M 215	4. How the corrective action will be monitored to ensure the deficient practice will not reoccur; what QA program will be put into place: The Executive Director or designee will review the grievance log weekly for completion for three months. The Executive Director or designee will bring the weekly grievance log audit to QAPI for three months than reassess. The Director of Clinical Services will review the psychotropic medication review form weekly for behavioral and symptom changes for three months. The Director of Clinical Services will bring the psychotropic medication audit to QAPI for three months than reassess. The Executive Director or designee will review the RIDOH survey deficiencies and plan of Corrections with the IDT when applicable. Compliance by 5/1/22. The Executive Director or designee will review RIDOH plans of correction during monthly QAPI Meetings. M215 Brookdale Sakonnet Bay obtains evidence of immunity for all health care workers in accordance with the rules and regulations Pertaining to Immunization, Testing, and	

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M 215	Continued From page 6 his/her scope of practice) certification that the health care worker is free of active disease shall be required... (5) A physician, certified registered nurse practitioner, or a physician assistant may certify that the health care worker is currently free of TB based on his/her clinical judgment for complex cases or unusual circumstances that do not fit the above criteria..." 1) Record review of Certified Nursing Assistant (CNA) Staff B, revealed a hire date of 03/15/2021. The record failed to reveal evidence of an up-to-date Tdap or influenza vaccination or an influenza declination, as required. 2) Record review of CNA Staff E, revealed a hire date of 10/22/2021. The record failed to reveal evidence of a vaccination for influenza or an influenza vaccination declination, as required. 3) Record review for Registered Nurse (RN) Staff F, revealed a hire date of 02/09/2022. The record failed to reveal evidence of a vaccination for influenza or an influenza vaccination declination. The record also failed to reveal evidence of a two-step PPD administered correctly, as required. During an interview on 03/17/2022 at approximately 12:30 PM, the Director of Clinical Services was unable to provide evidence of the above required documentation.	M 215	Health Screening for Health Care Workers promulgated by the Department of Health. 1. Corrective actions taken for residents found to have been affected by the deficient practice: No residents were found to have been affected by this practice. On 4/12/22 Staff B provided proof that she received her t-dap immunization on 12/1/2020 to the Director of Clinical Services. Staff B completed and signed the annual influenza declination form on 4/12/22. On 4/12/22 Staff E signed the annual influenza declination form. On 4/13/22 the Executive Director completed a record review and found a completed and signed annual influenza declination form for Staff F. On 3/16/22 the Assistant Director of Clinical Services administered the second step PPD to Staff F. 2. Corrective actions taken to identify other residents having the same potential to be affected by the same deficient practice: An audit of the facility Influenza Surveillance Program for health care center associates was completed on 4/13/22 by the Executive Director. Associates that did not receive the annual influenza vaccine will be	
M 285	REPORTING RES. ABUSE, ACCIDENTS & DEATH 1.15.1.B-D. Medical Records 1.15.1.B. Entries in the medical record relating to treatment, medication, diagnostic tests and other	M 285		

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M 285	Continued From page 7 similar services rendered shall be made by the responsible persons at the time of administration. Only physicians shall enter or authenticate medical opinions or judgment. 1.15.1.C. All accidents, including falls, whether resulting in an injury or not, shall be immediately recorded in the resident's record. 1.15.1.D. Detailed descriptions of all pressure ulcers, or other skin lesions, shall be recorded in the resident's record. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to record a detailed description of all pressure ulcers relative to 1 of 1 resident with a pressure ulcer, Resident ID #6. Findings are as follows: Record review of the resident revealed s/he was admitted to the facility in December of 2021 with diagnoses including, but not limited to: dementia, mild cognitive impairment, and history of a pressure ulcer of the sacral region, stage 3 (full thickness of the skin and may extend into the subcutaneous tissue). Further review revealed a "Weekly Skin Integrity Review" dated 02/08/2022 which revealed the resident's skin was not intact and a new skin issue was identified on the resident's sacrum which measured 1 centimeter (cm) in length by 0.5 cm in width and 0.1 cm of depth with a pink wound bed. Review of a document titled "Weekly Wound Data Collection Flow Sheet" dated 02/17/2022 revealed the resident had a pressure wound	M 285	offered the vaccination or instructed to sign declination forms by 5/1/22. An audit of facility t-dap compliance for health care center associates was completed on 4/13/22 by the Business Office Coordinator. No other associates were found to be without the required t-dap immunization. An audit of two-step PPDs will be completed by the Business Office Coordinator by 5/1/22. Any associate without proper administration will be re-tested by 5/1/22 3. Measures put into place and systemic changes made to ensure that the deficient practice does not recur: An Influenza Surveillance Program and tracking system (binder) has been updated to include a current roster of active associates at this facility. Upon hire, the Business Office Coordinator or designee will record evidence of administration immunization dates in the tracking system. Upon hire the Business Office Coordinator will document pre-screening immunization records, including but not limited to t-dap and PPD, in the individual associate medical record files. Furthermore, the Executive Director will re-educate the Director of Financial Services and Business Office Coordinator on pre-hire	

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M 285	Continued From page 8 which was first identified on 02/14/2022 that was located on the coccyx and measured 0.7 cm in length and 0.7 cm in width. The wound was further described with 100% pale pink tissue in the wound bed and wound edges intact and scant serosanguineous drainage. A treatment order was indicated on the form which stated, "Cleanse with NS [normal saline] and apply Allevyn [absorbent wound dressing] dressing 3x/week and as needed." Review of a "Weekly Skin Integrity Review" dated 02/22/2022 revealed the resident has a stage 2 (partial thickness skin loss) pressure wound on the sacrum. The document failed to reveal any further description of the wound. Review of a "Weekly Skin Integrity Review" dated 03/08/2022 revealed the resident's coccyx was red and blanchable. The document failed to reveal any further description of the wound. During an interview on 03/17/2022 at approximately 11:35 AM, Registered Nurse Staff G revealed she had not seen the resident's skin since Sunday and was unable to provide a description of the wound bed. During an interview on 03/17/2022 at approximately 1:15 PM, the Assistant Director of Nursing was unable to provide evidence of detailed descriptions of the pressure wound.	M 285	immunization requirements including t-dap, annual influenza vaccine, and PPD. 4. How the corrective action will be monitored to ensure the deficient practice will not reoccur; what QA program will be put into place: The Executive Director or designee will audit three new hires monthly for pre-screening immunization documentation, including but not limited to t-dap and PPD, for 90 days. The Executive Director or designee will provide to the QAPI committee a compliance status report of associate immunization compliance. This report will be given to the QAPI committee monthly for 90 days than reassess. Compliance by 5/1/22. The Executive Director or designee will audit current associate roster during influenza season for administration of vaccination or declination. The Executive Director or designee will bring the current associate influenza vaccination or declination compliance to QAPI meeting monthly for 90 days than reassess.	
M 595	RESIDENT CARE SERVICES 1.16.1.A. Resident Care Policies 1.16.1.A. Each nursing facility shall have written resident care policies to govern the continuing nursing care and related medical or other	M 595	M285 Brookdale Sakonnet Bay makes entries in the medical record relating to treatment, medication, diagnostic tests, and other	

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M 595	Continued From page 9 services provided. 1. Care practices shall be person-centered in their implementation and resident-directed in their development whenever possible, and 2. The nursing facility shall provide care and services to all residents in accordance with the prevailing community standard of care. 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 care and services to all residents in accordance with prevailing community standard of care relative to: security of the medication cart, 1 of 1 resident reviewed with a surgical wound, Resident ID #1 and 1 of 3 residents reviewed for nutritional status, Resident ID #6. Findings are as follows: 1. Review of the facility policy titled, "Security of Medication Cart," states in part: "Policy Overview The medication cart shall be secured during the medication passes. Policy Detail A. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry. B. The cart should be locked before the nurse enters the resident's room. C. Medication carts must be securely locked at all times when out of the nurse's direct observation..."	M 595	similar services including detailed descriptions of all pressure ulcers and skin lesions. 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? On 3/17/2022 Assistant Director of Clinical Services reassessed resident ID#6 skin, weekly skin integrity form completed. No other skin issues noted. Previous skin issues resolved. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? On 3/18/2022 Assistant Director of Clinical Services audited residents wound documentation forms, and weekly skin integrity forms in PCC. Found no other residents affected. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? On 3/18/2022 Assistant Director of Clinical Services re-educated nurses on documentation of wounds, wound measurements on the Wound Evaluation Flow Sheet, and Weekly Skin integrity form. Assistant Director of Clinical Services or designee will audit 3 residents with active wounds for Weekly Wound Documentation Forms and skin	

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M 595	Continued From page 10 During a surveyor observation on 03/16/2022 at 11:52 AM with Registered Nurse Staff F, he was observed preparing to perform a blood glucose test for Resident ID #3. He then walked away from the medication cart and did not lock the cart. He returned to the cart to prepare an insulin injection for the resident. He then proceeded to the resident's room, leaving the cart unlocked and unattended. Staff F then continued to perform the medication pass for Resident ID #1 and 8 while leaving the medication cart unlocked and unattended. During an interview with Staff F immediately following the observation, he acknowledged he left the medication cart unlocked while performing a medication pass. During an interview on 03/09/2022 at approximately 12:30 PM, the Director of Clinical Services acknowledged that the medication cart should be locked while unattended as stated in the facility policy. 2. The facility's policy titled "Skin Observation and Wound Prevention Protocol", states in part, "...Charge nurses will observe the condition of the resident's skin on admission and on a routine basis...Weekly: The Charge Nurse Should...Document any integumentary findings including the dressing being removed (if indicated), the appearance of the wound, and treatment applied...Initiate treatment interventions per health care provider order for new or newly identified wounds. If a wound is present, the Charge Nurse will initiate or continue to describe the wound on the Weekly Wound Data Collection Sheet...Update plan of care with each	M 595	integrity for compliance weekly for three months. 4. How will the facility monitor its' performance to make sure that solutions are sustained? Assistant Director of Clinical Services or designee will bring results of audits to monthly Quality Assurance and Performance Improvement meetings for three months then reassess. Compliance by 5/1/22. M595 Brookdale Sakonnet Bay provides care and services to all residents in accordance with prevailing community standards of care relative to: security of the medication cart, observation of resident wound status, and notification of changes in resident weight. 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? On 3/17/2022 Director of Clinical Services verified medication cart was locked. On 3/17/2022 Assistant Director of Clinical Services completed Weekly Wound Data Collection Form and care plan updated for resident ID#1. On 3/17/2022 The Director of Clinical Services reviewed Resident ID #5 Registered Dietician recommendations for completion, verified weekly weight	

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M 595	Continued From page 11 intervention..." Record review revealed Resident ID #1 has a diagnosis including, but not limited to, squamous cell carcinoma (cancer) of the skin. Record review of a physician's report dated 03/08/2022 states in part, "...Treatment...Squamous cell carcinoma of scalp Clinical Notes; seen by derm [dermatology] today s/p [status post] shave removal and destruction, dressing to be left in place x [for] 48 hours, then cleanse daily..." Further review of the medical record failed to reveal evidence that a "Weekly Wound Data Collection Flow Sheet" was completed after the dressing was scheduled to be removed on 03/10/2022. Additional record review failed to reveal that the care plan was updated to reflect the changes to the resident's skin. During an interview on 03/17/2022 at approximately 11:45 AM, Staff F was unable to provide evidence that the "Weekly Wound Data Collection Flow Sheet" was completed per policy. During an interview on 03/17/2022 at approximately 1:00 PM, the Director of Clinical Services acknowledged that the care plan was not updated to identify interventions for Resident ID #1's surgical incision. 3. Review of a facility policy and procedure titled "Weight Management Guidelines" states in part: "Policy	M 595	order in place and notification of MD and dietician of significant weight change completed. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? On 3/17/2022 Director of Clinical Services verified medication cart was locked. On 3/18/22 Assistant Director of Clinical Services reviewed resident charts with active wounds for completion of weekly wound documentation. There were no other residents found to be affected by deficient practice. On 3/18/2022 Assistant Director of clinical services reviewed resident charts with active wounds to observe care plans reflect resident's current status. There were no other residents found to be affected by deficient practice. On 3/18/2022 Director of Clinical Services reviewed for the month of March Dietary recommendations for completeness. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? On 3/18/2022 Director of Clinic Service reeducated nurses on facility policy of security of medication cart, being locked when not in attendance. Additionally, on 3/18/2022 Assistant Director of Clinical Services re-	

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M 595	Continued From page 12 The Nursing Department should provide the Food and Nutrition Services Department with the monthly and weekly weights of each resident as needed. Residents with significant weight variance should be identified and appropriate interventions implemented." Review of a policy titled, "Weight and Height Policy" states in part: "Policy Overview Residents should be weighed upon admission/re-admission, weekly for 3 weeks, as as needed... Policy Detail A. Weight 3...for 2 pounds, weight variance, conduct a re-weigh s needed for accuracy...notify the charge nurse of weight variances as indicated ..." Record review revealed Resident ID #5 was admitted to the facility in December of 2021 with diagnoses that include but are not limited to: Parkinson's disease, mild cognitive impairment, and dementia. Further review revealed on admission the resident weighed 194 pounds (lbs.). On 01/16/2022 the resident weighed 192.7 lbs. and on 02/01/2022 the resident weighed 181.7 lbs. This is indicative of a 5.71% weight loss in 1 month. The record failed to reveal evidence the physician or registered dietitian were notified of a significant weight loss, nor that the resident was re-weighed	M 595	educated license nurses on the policy entitled "Skin Observation and Wound Prevention Protocol". Also, on 3/18/2022 Director of Clinical Services re-educated nurses on weight and height policy including but not limited to initiation of change of condition for significant weight change and notification of dietician and physician. The license nurse will securely lock the medication cart at all times when out of direct observation to prevent unauthorized entry. The license nurses will observe the condition of the resident's skin on admission and on a routine basis. Upon admission the Charge Nurse will complete physical observation, documenting findings within the Admission Data Collection form. If a wound is present on admission the Charge Nurse will initiate and describe the wound on the Weekly Wound Data Collection Sheet. The license nurse or designee will initiate plan of care to reflect current status. The license nurse will document weekly any integumentary findings including the dressing being removed (if indicated), the appearance of the wound, and treatment applied/initiated per health care provider. The license nurse or will review and revise the plan of care to reflect the resident current status.	

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M 595	Continued From page 13 after a weight discrepancy, per policy. Review of a progress note dated 02/12/2022 written by the registered dietitian revealed a recommendation for weekly weights and to add a supplement three times a day. Review of the physician's orders revealed weekly weights were not ordered or completed until 03/06/2022 and a supplement was not ordered or implemented until 02/28/2022. Upon review of the weight record it was revealed that weekly weights were not obtained from 02/12/2022 - 03/06/2022. On 03/06/2022 the resident weighed 176 lbs. During an interview on 03/17/2022 at approximately 11:00 AM, the Director of Clinical Services revealed she would expect recommendations from the dietitian to be put into place within 24-48 hours after they were made and was unable to explain why the resident was not re-weighed after a weight discrepancy of 5.71% was identified.	M 595	Upon admission/re-admission the nurse will obtain an order from the primary care physician to weigh the resident on admission, weekly for three weeks, and as needed. The licensed nurse will obtain an order from the primary care physician within 72 hours to complete dietary recommendation. 4. How will the facility monitor its' performance to make sure that solutions are sustained? The Director of Services or Designee will audit the medication cart for being locked when out of line of sight of the license nurse 3 times a week for 3 months. The Director of Clinical Services or designee will bring medication cart being locked audits to monthly Quality Assurance Performance Improvement meeting x 3 months then reassess. Director of Clinical Services or designee will audit 3 residents a week with active wounds to observe weekly wound data collection form has been completed and care plans have been reviewed and revised to reflect the resident current status. Director of Clinical Services or designee will bring weekly wound data collection audits to monthly Quality Assurance Performance Improvement meeting x 3 months then reassess.	
M 790	RESIDENT CARE SERVICES 1.16.9.A. Administration of Drugs 1.16.9.A. Drugs shall be administered in accordance with written orders of the attending physician and procedures established in accordance with §§ 1.17.4(A) and (B) of this Part. Such procedures shall include measures to assure: 1. that drugs are checked against physicians', physician assistants ' , or advanced practice registered nurses ' orders;	M 790		

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M 790	Continued From page 14 2. that the resident is identified prior to administration of a drug; 3. that each resident has an individual medication record; and 4. that the dose of drug administered to each resident is properly recorded therein by the person administering the drug. 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 administer medication in accordance with physician orders for 1 of 1 sample resident reviewed for oxygen administration, Resident ID #4. Findings are as follows: 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." According to Basic Nursing, Mosby, 3rd: "after administering a drug, the nurse records it immediately on the appropriate record form. Recording the drug includes the name of the drug, dosage, route of administration and exact time of administration." Record review for Resident ID #4 revealed an admission date of March 2022 with a diagnosis of acute and chronic respiratory failure with hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions).	M 790	Director of Clinical Services or Designee will audit 3 new admissions weekly for weight orders entered per protocol, weekly weights being obtained and weekly dietary recommendations for completion. Director of Clinical Services or designee will bring admission weight orders, weights obtained x 3 weeks and weekly dietary recommendation audits to monthly Quality Assurance Performance Improvement meeting x 3 months then reassess. Director of Clinical Services or designees will review results of audit checks at Quality Assurance and Performance Improvement meetings for 3 months. Assistant Director of Clinical Services or designee will bring results of audits to monthly Quality Assurance and Performance Improvement meetings for 3 months. Assistant Director of Clinical Services or designee will review compliance with recommendations in Quality Assurance and Performance Improvement meetings for three months. Compliance by 5/1/22. M790 Brookdale Sakonnet Bay administers medication in accordance with physician orders. 1. How will the corrective action be accomplished for those residents	

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M 790	Continued From page 15 Review of the physician orders reveals the following entries: -03/02/2022 2 liters of oxygen per nasal cannula (a device used to deliver supplemental oxygen or increased airflow to a patient) every shift for hypoxia -03/04/2022 maintain oxygen saturation above 90% -03/08/2022 goal is to wean off oxygen Surveyor observations of the resident on 03/16/2022 at 8:45 AM, 1:35 PM, and at 3:50 PM, revealed the resident to be receiving 4 liters of oxygen. An additional surveyor observation on 03/17/2022 at 10:00 AM revealed the resident to be receiving 4 liters of oxygen. Record review failed to revealed evidence that an attempt was made to wean the resident from the oxygen therapy. During an interview on 3/17/2022 at approximately 10:30 AM, Registered Nurse Staff A stated that the resident came from the hospital on 2 Liters of oxygen. She further stated that the resident is getting 2 Liters of oxygen every shift, according to the Medication Administration Record. She indicated that the facility has not tried to wean the resident off oxygen. Following the interview, the surveyor followed Staff A into the resident's room to check the resident's oxygen saturation level. Staff A acknowledged that the resident was receiving 4	M 790	found to have been affected by the deficient practice? On 3/17/2022 Director of Clinical Services verified resident ID #4 oxygen order from MD and corrected liter flow on concentrator. **2.** How will the facility identify other residents having the potential to be affected by the same deficient practice? On 3/18/22 the Director of Clinical Services audited current orders for Oxygen. No other residents were affected by the deficient practice. **3.** What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? On 3/18/2022 the Director of Clinical Services re-educated the license staff on policy entitled "General Dose Preparation and Medication Administration". (This policy Is found in the Omnicare Pharmacy manual page 99) Prior to administration of medication, a licensed nurse will take all measures to verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident according to physician orders.	

MR 7/17/22

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M 790	Continued From page 16 liters of oxygen. During an interview on 03/17/2022 at approximately 11:00 AM, the Director of Clinical Services acknowledged that the oxygen was not administered in accordance with the physician's orders.	M 790	4. How will the facility monitor its' performance to make sure that solutions are sustained? Director of Clinical Services or designee will audit 3 residents' charts weekly with active orders for oxygen and observe liter flow matches the order times 90 days. Director of Clinical Services or designee will review results of audit compliance for three months then reassess in Quality Assurance and Performance Improvement meetings for three months. Compliance by 5/1/22.	
M 880	DIETETIC SERVICES 1.17.3.G. Dietetic Services 1.17.3.G. The nursing facility ' s food service operation shall comply with all appropriate standards of the Rhode Island Food Code (Part 50-10-1 of this Title). 1. Diet kitchens, nourishment stations, and any other related areas shall be the responsibility of the dietetic service. This Requirement is not met as evidenced by: Based on surveyor observation, record review, and staff interview it has been determined the facility failed to comply with the appropriate requirements of the Rhode Island Food Code. Findings are as follows: 1) Section 4-601.11 of the Rhode Island Food Code requires that "... (C) Non FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris..." During a surveyor observation of the kitchen on 03/15/2022 at approximately 9:00 AM the surface area under the kitchen hoods were noted to have a significant accumulation of dust and debris, in addition to accumulated dried drips of grease on the side surface of the unit.	M 880 MR 4/18/22	M880 Brookdale Sakonnet Bay's Food Service operation complies with all appropriate standards of RI Food Code. Non-food contact surfaces are kept clean, equipment and utensils are properly air-dried, time and temperature control for safety is maintained, and handwashing sinks are equipped to provide water at least 100° F, 1. Corrective actions taken for residents found to have been affected by the deficient practice: On 3/15/22, the shift dishwasher/sanitation associate cleaned the hood of the accumulation of dust and debris as well as the identified grease drips. On 3/15/22 Director of Dining Services updated the daily and weekly cleaning schedule.	

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M 880	Continued From page 17 A review of the March "Daily and Weekly Cleaning Schedule" revealed that the vent hood filters were not signed off as cleaned. 2) Section 4-901.11 of the Rhode Island Food Code requires that, "...After cleaning and SANITIZING, EQUIPMENT and UTENSILS (A) Shall be air-dried..." During a surveyor observation of the kitchen on 03/15/2022 at 9:15 AM and on 03/16/2022 at approximately 10:00 AM revealed 3 rows of wet stainless steel pans stacked upon one another. During an interview on 03/16/2022 at 10:00 AM, the Food Service Director (FSD) acknowledged the pans were stacked wet. 3) Section 3-501.16 (A) of the Rhode Island Food Code requires that, "...Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained:...(2) At 5°C (41°F) or less..." Record review of the March "Temperature Log" of a 3-door refrigerator in the main kitchen revealed 9 out of 57 temperatures (15.7%) were above 43 degrees. Additionally, corrective action was not taken until the surveyor brought this to the attention of the FSD on 03/15/2022. During a surveyor interview on 03/15/2022 at approximately 9:10 AM, the FSD could not produce evidence that corrective action was	M 880	On 3/16/22, the on shift dishwasher re-sanitized and separating the identified wet pans. The dishwasher was also re-educated on stacking pots for air-drying by the Director of Dining services. On 3/16/22 the server closed the door to allow the temperature to return with in a safe range. On 3/16/22, the reported refrigerator was serviced and repaired by SS Service Corp. On 3/17/22 dining associates were educated on approaches to retain refrigerator temperatures during times of loading. The identified hot water supply to the hand sink was immediately resolved on 3/15/22 by our Maintenance Technician by opening the diversion valve in the utility room. 2. Corrective actions taken to identify other residents having the same potential to be affected by the same deficient practice: Other non-food contact surfaces in the kitchen, including equipment surfaces in the food preparation areas, were inspected on 3/15/22 by the Dining Services Director. No other non-food contact surfaces were affected. Inspection of the dish areas on 3/15/22 by the Director of Dining Services	

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M 880	Continued From page 18 taken to ensure refrigeration temperatures remains at 41°F or below. 4). Section 5-202.12 (A) of the Rhode Island Food Code requires that, "A HANDWASHING SINK shall be equipped to provide water at a temperature of at least 38 °C (100 °F) through a mixing valve or combination faucet..." Surveyors' observations of the facility dining room and kitchenette on 03/16/2022 from 11:45 AM -1:30 PM revealed dietary staff plating and delivering meals to the residents. Staff was observed during this time using the hand washing sink. At approximately 1:30 PM on 03/16/2022, the surveyors observed the kitchenette handwashing sink lacked hot water. Temperatures taken from this sink did not exceed 40 degrees. During an interview on 03/17/2022 at approximately 1:35 PM, Staff D, Maintenance Assistant, acknowledged that the water coming from the faucet in the kitchenette was cold and there was no hot water available. He indicated there is a diversion of the hot water in the utility room, which needs to be manually corrected in order for hot water to reach the kitchenette sink.	M 880	found no further instances of wet stacked pots, pans, or utensils. Each refrigerator in the main kitchen were checked on 3/15/22 by the Dining Director and no further instances of low temperatures were observed. The hand sinks throughout the health care center were checked on 3/15/22 by the Director of Maintenance for hot water supply and found no other instances where hot water was not available. 3. Measures put into place and systemic changes made to ensure that the deficient practice does not recur: On 3/15/22 the Dining Services Director educated kitchen staff on the process of cleaning non-food contact surfaces including the hood. In order to prevent re-occurrences, assigned associates will clean non-food contact surfaces in the kitchen and will document on the Daily Cleaning Log.	
M1185	ENVIRONMENTAL & MAINTENANCE SERVICES 1.18.2.G. Laundry Services 1.18.2.G. A quantity of linen equivalent to three (3) times the number of beds including the set of linen which is actually in use shall be available and in good repair at all times.	M1185	On 3/15/22 the Dining Services Director re-educated the kitchen staff on the process on air-drying pots, pans, and utensils. Upon washing pots, pan, and utensils the dishwasher or designee will properly stack to meet air-dry requirements. Also, daily inspections	

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M1185	Continued From page 19 This Requirement is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined the facility failed to maintain a quantity of linen equivalent to three (3) times the number of beds including the set of linen which is actually in use. Findings are as follows: The facility has 30 licensed beds. During an interview on 03/16/2022 at approximately 9:30 AM, the Administrator indicated bed linens are supplied by an outside vendor. Record review of invoices from the vendor dated 12/21/2021-03/08/2022 failed to reveal bed linen delivery. During an interview on 03/17/2022 at approximately 10:45 AM, Certified Nursing Assistant Staff C, indicated the closet and the linen cart in room 163 are the only places where the facility bed linens are stored. During surveyor observations on 03/17/2022 at approximately 11:00 AM, there were a total of 19 addition bed sheets available between the linen cart and the linen closet, aside from those in use. During an interview on 03/17/2022 at approximately 12:00 PM, the Administrator acknowledged there were no bed linens on the invoices provided and the total bed linens available does not meet the required amount.	M1185 MR 4/18/22	of the dish washing stations will be checked and documented to assure equipment and utensils are properly air-dried. Furthermore, the refrigerator temperatures will be checked and documented and service contacted to assure holding temperatures are appropriate to safely keep foods. Lastly, water temperatures throughout the building will be monitored and checked on a daily basis. These temperature checks are completed at varying locations including resident room sinks, showers, laundry rooms, and common areas. Handwashing sinks will be included daily for three month than reevaluated. 4. How the corrective action will be monitored to ensure the deficient practice will not reoccur; what QA program will be put into place: The Director of Dining Services will review results of the non-food contact audits, the dish area audits, and refrigerator temperatures with the monthly QAPI committee for three months then reassess. The Maintenance Director will review results of water temperature compliance, especially at handwashing sinks, with the monthly QAPI committee for three months then reassess. Compliance by 5/1/22.	
M1215	ENVIRONMENTAL & MAINTENANCE SERVICES 1.18.3.E. EOP/COOP	M1215		

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M1215	Continued From page 20 1.18.3.E. Simulated drills testing the effectiveness of the EOP plan shall be conducted at least annually and/or in conjunction with local emergency preparedness drills. Written reports and evaluation of all drills shall be developed and maintained by the nursing facility. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to conduct simulated drills testing the effectiveness of the emergency operations plan (EOP) plan at least annually and/or in conjunction with local emergency preparedness drills. Findings are as follows: 1) Record review of the facility policy "Emergency Preparedness-Training, Drills and Testing Policy" review date of 04/2018, states in part, "...Each community shall participate the following exercise drills annually, at a minimum. 1. Full-scale Community-based Exercise Drill procedure includes the following: a. Contact local and state agencies and healthcare coalitions, where appropriate, to participate in the exercise drill ...Additional Exercise may include, but are not limited to the following: a. A second full-scale exercise that is community based or individual community-based. B. A table top exercise..." The facility failed to have documentation of a full scale EOP simulated drill for 2019, 2020, and 2021. During an interview on 03/17/2022 at approximately 10:45 AM, the Administrator acknowledged there was no evidence of a	M1215 MR 4/18/22	M1185 Brookdale Sakonnet Bay makes available a quantity of linen equivalent to three times the number of beds including the set of linen which is in use. Linen is maintained in good condition. 1. Corrective actions taken for residents found to have been affected by the deficient practice: At no time were residents without clean and in good condition bed linens. Bed linen counts were done on 3/16/22 by the Maintenance Director and Maintenance Technician. On 3/18/22 facility associates delivered 48 fitted sheets to the Health Care Center. On 4/13/22 facility designee ordered an additional supply of bed linens which arrived at the facility and increased our inventory of bed linen to the appropriate levels. 2. Corrective actions taken to identify other residents having the same potential to be affected by the same deficient practice. No other instances were identified or found to have been affected. 3. Measures put into place and systemic changes made to ensure that the deficient practice does not recur. In order to assure our bed linens are at the appropriate inventory levels, and to prevent our bed linens from dropping below the minimum inventory counts	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LTC00774	A. BUILDING: _____ B. WING _____	03/17/2022

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M1215	Continued From page 21 full-scale EOP drill in 2019, 2020, and 2021. 2) Record review of the facility policy "PointClickCare (PCC) [the facility's health record system] Unplanned Downtime Process Drills Policy" effective date of 1/2019, states in part, "...PointClickCare Unplanned Downtime Process drills should be conducted quarterly on alternating shifts..." The facility failed to have evidence of PointClickCare Unplanned Downtime Process drills. During an interview on 03/17/2022 at approximately 10:20 AM, the Director of Clinical Services was unable to provide evidence of these drills testing the electronic health record system for emergency purposes per facility policy.	M1215 MW 4/18/22	(90 sets), this facility will complete weekly bed linen inventory counts for the next 4 weeks and periodic audits by community designee thereafter. Any bed linens in poor condition will be discarded and orders placed as needed to replenish and bring back to minimum levels. Furthermore, each delivery of bed linens from our laundry processing vendor will be confirmed at the time of delivery to assure accurate inventory counts. 4. How the corrective action will be monitored to ensure the deficient practice will not reoccur; what QA program will be put into place. The Lead Housekeeper or facility designee will monitor the weekly bed linen counts and provide the results to the QAPI Committee monthly for three months than reassess. Compliance by 5/1/22. M1215 Brookdale Sakonnet Bay conducts simulated drills testing the effectiveness of the emergency operations plan at least annually and/or in conjunction with local emergency preparedness drills. 1. Corrective actions taken for residents found to have been affected by the deficient practice: On 3/23/22 the Executive Director contacted the Tiverton RI Fire	

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Department and spoke to the Fire Chief. A simulated evacuation drill for our Health Care Center will be completed on or before 4/27/22.

This facility also has scheduled an unplanned downtime process drill for our electronic medical record (EMR) system Point Click Care for 4/14/22.

2. Corrective actions taken to identify other residents having the same potential to be affected by the same deficient practice.
Brookdale Sakonnet Bay will conduct a simulated full-scale facility-based Emergency Operations Plan (EOP) exercise in conjunction with the local Tiverton RI Fire department (TFD).

MR
4/18/22

3. Measures put into place and systemic changes made to ensure that the deficient practice does not recur.
To prevent reoccurrence, this facility has now entered into TELS, our building maintenance program, a reoccurring annual task to conduct a full-scale community-based simulated exercise.

Furthermore, this facility as entered into TELS a quarterly reoccurring task to complete a Point Click Care (PCC) downtime process drill. The Director of Clinical Services Maintenance Director or designee will complete this task annually each April to assure no further reoccurrences.

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			4. How the corrective action will be monitored to ensure the deficient practice will not reoccur; what QA program will be put into place. The Maintenance Director will review results of any emergency preparedness drills completed, including any full-scale simulated EOP drills, at the QAPI meeting following completion of each such drill. The Director of Clinical Services will report on the results of the PCC downtime drills in the QAPI meeting and quarterly thereafter. Compliance by 5/1/22.	

MR
4/18/22