

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

PRINTED: 11/09/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415113	(X2) MULTIPLE CONSTRUCTION A. B U I L D I N G ----- B. WING	(X3) DATE SURVEY COMPLETED 11/04/2021
NAME OF PROVIDER OR SUPPLIER TOCKWOTTON ON THE WATERFRONT			STREET ADDRESS, CITY, STATE, ZIP CODE 500 WATERFRONT DRIVE. EAST PROVIDENCE, R 02914	
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F 000	INITIAL COMMENTS A Recertification Survey and Complaint/Incident Investigation Survey, ACTS Reference Numbers 79674, 80217 & 80822 were conducted at Tockwotton On The Waterfront from 11/01/2021 through 11/04/2021 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. A State licensure and emergency preparedness surveys were also conducted at this facility. As a result of this survey, the Facility was determined not to be in compliance with these requirements.	F 000		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care. Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice relative to 1 of 3 sample residents reviewed for constipation, Resident ID #200. Findings are as follows: Review of the facility's document titled, "Bowel Protocol" states in part, "...if no BM [bowel	F684	Resident ID #200 is alert and oriented. ■ has refused to adhere to the facility's standing bowel protocol since admission stating ■ dislike for prune juice and Milk of Magnesia. For that reason, ■ has only the customized Suppository and Fleets orders. ■ has been a resident at Tockwotton since 2017. In this time ■ has had no negative side effects from constipation using this regime. ■ orders have been modified and the orders have been clarified, but still only involve Dulcolax and Fleet enemas. All charts have been reviewed. There are no other residents in the facility that do not adhere to the "House Protocol". All nurses have been educated regarding the "House Protocol" as well as the specifics of resident #200 since ■ is the only one that deviates from it.	11-19-21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *President & CEO* (X6) DATE: *Nov. 22, 2021*

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 684	Continued From page 1 movement] times three days, the 7-3 shift administers 4 oz [ounces] of prune juice. If no results the 3-1p [PM] shift will administer 30 cc [cubic centimeter] of MOM [Milk of Magnesia, a medication used to treat constipation]. If no results the 11-7a [AM] shift will administer a Dulcolax sup. [suppository, a medication used to treat constipation]. If no results the 7-3p [PM] shift will administer a Fleets Enema [a medication used to treat constipation]. If still no results NP/MD [Nurse Practitioner/Medical Doctor] will be notified." Record review revealed the resident was admitted to the facility in November of 2017 with diagnoses including constipation, vascular disorder of intestine, unspecified ischemic colitis (when blood flow to part of the large intestines is temporarily reduced usually due to constriction of the blood vessels), and diverticulitis (an inflammation or infection in one or more small pouches in the digestive tract). Record review of the physician's orders revealed the following bowel medications: - 9/10/2018: "Dulcolax [bisacodyl] suppository; 10 mg [milligram]: Amount to Administer: 10 mg; rectal PRN [as needed] daily for constipation" - 4/19/2018: "Fleets enema 1 PR [per rectal] daily PRN for constipation if no results from dulcolax suppository..." Record review of the physician's orders failed to reveal evidence of orders for Milk of Magnesia and prune juice as indicated in the bowel protocol.	F 684	Each morning the 11-7 shift submits a census to the Director of Nursing. Ongoing the 11-7 nurse will also submit the daily Bowel Management Sheet along with the Census. The Director of Nursing or Designee will then review the Bowel Management Sheet on a daily basis to monitor for compliance and adherence to our policy. Audit results will evaluate and brought to the monthly QAPI meeting for three months and or until 100% compliance is obtained.		

MR
11/2/21

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F 684	<p>Continued From page 2</p> <p>Record review of the bowel movement (BM) documentation for October 2021 revealed the following:</p> <ul style="list-style-type: none"> - 10/1/2021 to 10/4/2021, no evidence of a BM for 4 days - 10/22/2021 to 10/25/2021, no evidence of a BM for 4 days - 10/27/2021 to 10/31/2021, no evidence of a BM for 5 days <p>Record review of the Medication Administration Record (MAR) for October 2021 failed to reveal evidence that the above-mentioned bowel protocol was implemented, and the bowel medications were administered as ordered from 10/1/2021 through 10/4/2021, from 10/21/2021 through 10/25/2021, and from 10/27/2021 through 10/31/2021.</p> <p>Record review of the BM documentation for September 2021 revealed the following:</p> <ul style="list-style-type: none"> - 9/29/2021 to 10/4/2021, no evidence of a BM for 6 days - 9/12/2021 to 9/21/2021, no evidence of a BM for 10 days <p>Record review of the MAR for September 2021 failed to reveal evidence that the above-mentioned bowel protocol was implemented, and that the bowel medications were administered from 9/1/2021 through 9/11/2021 and from 9/12/2021 through 9/21/2021.</p> <p>During a surveyor interview on 11/3/2021 at 11:03</p>	F 684			

PKK
10/27/21

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F 684	Continued From page 3 AM with the Director of Nursing Services (DNS) in the presence of the Assistant Director of Nursing Services, both staff acknowledged that the bowel protocol was not implemented. Additionally, the DNS acknowledged that the bowel medications were not administered as ordered.	F684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that: (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's	F 690 <i>W</i> <i>4/10/21</i>	Resident #25 has been re-educated again regarding appropriate infection control regulations and best practices. These include, location of bag, covering the bag, placement of tubing and the importance of leaving the bag in the location the Nursing Assistants place it. She is alert and oriented. The resident's frequent noncompliance has been added to her care plan. There are two other residents that have catheters that drain into a bag and upon frequent inspection they are placed appropriately with the utmost of attention paid to Infection Control Practices. All staff has also been re-educated on Best practices and Regulations. Upon doing rounds at the beginning of each shift the charge nurse will note placement of the foley bag and tubing for all residents. The charge nurse will document on the audit sheets and submit to the Director of Nursing or her designee daily for three months. The results will be evaluated and brought to the monthly QAPI meeting for review.	11-19-21

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F 690	<p>Continued From page 4</p> <p>comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide appropriate treatment and services for care of a resident with an indwelling catheter for 1 of 3 sample residents reviewed, Resident ID #25.</p> <p>Findings are as follows:</p> <p>The Center for Disease Control and Prevention (CDC) document titled, "Guideline for Prevention of Catheter Associated Urinary Tract Infections 2009" states in part, "...III Proper techniques for Urinary Catheter Maintenance...III.B.2 Do not rest the bag on the floor..."</p> <p>Review of the facility's policy titled, "Catheter Care, Urinary" states in part, "...Infection Control 2.b. Be sure the catheter tubing and drainage bag are kept off the floor..."</p> <p>Record review for this resident revealed s/he was admitted to the facility in May of 2021 and has diagnoses including, but not limited to, neuromuscular dysfunction of bladder (a lack of bladder control due to brain, spinal cord, or nerve problems), and urinary tract infection.</p> <p>Further record review revealed a physician's order dated 9/1/2021 for a Foley catheter (a tube placed in the bladder to drain urine), daily, size 20 French.</p>	F 690		

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11/29/21

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F 690	<p>Continued From page 5</p> <p>Surveyor observations revealed the following:</p> <ul style="list-style-type: none"> - 11/1/2021 at 10:05 AM, 10:20 AM, 11:29 AM, the resident was observed sitting in a recliner, the catheter bag attached to the trash bin, and both the bag and tubing were directly on the floor. At 10:20 AM, two Nursing Assistants were observed entering and exiting the resident's room while the catheter bag and tubing remained directly on the floor. - 11/2/2021 at 8:40 AM and 2:22 PM, the resident was observed sitting in a recliner, the catheter bag attached to the trash bin, and both the bag and tubing were directly on the floor. - 11/3/2021 at 8:57 AM, 9:47 AM, 10:39 AM, 11:09 AM, and 11:19 AM, the resident was observed sitting in a recliner, the catheter bag attached to the trash bin, and both the bag and tubing were directly on the floor. At 9:47 AM, two Nursing Assistants were observed entering and exiting the resident's room while the catheter bag and tubing remained directly on the floor. <p>During a surveyor interview on 11/3/2021 at 11:26 AM with Registered Nurse, Staff A, she acknowledged that the catheter bag was directly on the floor.</p> <p>During a surveyor interview on 11/3/2021 at 1:57 PM with the Director of Nursing Services, she indicated that she would expect the catheter bag to be attached to the side of the resident's recliner, should not be attached to the trash bin, and should not be resting directly on the floor. She further indicated that she would expect the staff to remove the catheter bag from the floor if it</p>	F690		

*WCR
11/2/21*

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F 690 F 695 SS=E	<p>Continued From page 6 was observed there.</p> <p>Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)</p> <p>§ 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:</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice for 1 of 4 residents reviewed for oxygen therapy, Resident ID #34.</p> <p>Findings are as follows:</p> <p>Review of the facility policy titled, "Pulse Oximetry (Assessing Oxygen Saturation)," revealed in part, "...Documentation...the following information should be recorded in the resident's medical record:...Any unusual findings and action taken..."</p> <p>Review of the record revealed the resident was admitted to the facility in November 2020 with diagnoses including, but not limited to, chronic diastolic congestive heart failure (a condition where the lower left chamber of the heart (left ventricle) is not able to fill properly with blood).</p> <p>1. Review of the record revealed a 5/25/2021</p>	F690 F695	<p>The order was discontinued from the resident's 11-19-21 chart immediately upon discovery.</p> <p>All resident oxygen orders were reviewed. Each has a liter flow, route (mask, cannula) and directive for use. All were in compliance.</p> <p>Nurses have been re-educated regarding specific mandated requirements, regarding obtaining and following an oxygen order.</p> <p>All oxygen orders will be reviewed by Nursing Managers upon receiving and the results of the audits will be presented at the QAPI meeting for three months and or until 100% compliance is obtained.</p>	

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F 759	<p>Continued From page 8</p> <p>§483.45(f) Medication Errors. The facility must ensure that its-</p> <p>§483.45(f)(1) Medication error rates are not 5 percent or greater; 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 ensure that each resident's medication regimen is free from a medication error rate of 5% or greater. Based on 25 opportunities for error observed during the medication administration task, there were 2 errors resulting in an error rate of 8%, involving Resident ID #'s 37 and 40.</p> <p>Findings are as follows:</p> <p>1. Record review revealed Resident ID #37 has a physician's order for "Levothyroxine [drug used to treat thyroid conditions] 112 meg [micrograms] PO [by mouth]. Description: 1st AM Med [medication] Start Time: 05:00 AM End Time: 10:00 AM." The pharmacy label's instructions state, "...Take on an empty stomach..." Additionally, the manufacturer's instructions state in part, "Administer once daily... one-half to one hour before breakfast."</p> <p>During an observation of the medication administration task on 11/3/2021 at 8:35AM with Licensed Practical Nurse, Staff B, she administered the above medication to the resident.</p> <p>During an interview immediately following this observation with Staff B, she revealed that the resident received the above medication before</p>	F 759	<p>The residents, #37 and #40 have had the orders changed. Rather than just pre-breakfast with a wide time range, it is now specified 5:30-6:30.</p> <p>All residents having orders for medication to be given on any empty stomach were reviewed. All of the orders that had specific administration times. They did not have to be changed to 5:30-6:30am.</p> <p>All nurses and Certified Medication Technicians we re-educated regarding the timeliness of this medication administration. Included in this education was the importance and effectiveness of medication administration. All nurses were also instructed to override automatic time ranges our computer system generates.</p> <p>Consultant pharmacist will audit on a monthly basis to be sure this practice is followed. Nursing Managers will also audit all new orders and bring results to QAPI meeting monthly for three months or until 100% compliance is obtained.</p>
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F 759	<p>Continued From page 9</p> <p>breakfast and that s/he cannot eat until "about an hour" after it has been administered.</p> <p>During a surveyor observation on 11/3/2021 at 8:43AM, the resident was observed eating breakfast in his/her room.</p> <p>2. Record review revealed Resident ID #40 has a physician's order for "Levothyroxine 50 meg PO. Description: PRE- Breakfast Start Time: 05:00 AM End Time: 11:00 AM."</p> <p>During an observation of the medication administration task on 11/3/2021 at 8:38AM with Staff B, she administered the above medication to the resident.</p> <p>During an observation of the resident on 11/3/2021 at 9:10AM, s/he was observed eating breakfast in the main dining room.</p> <p>During a surveyor interview with Staff B at 9:25 AM, she acknowledged that the resident has been eating breakfast for ten minutes.</p> <p>During a surveyor interview with the Director of Nursing Services on 11/3/2021 at 1:49 PM, she revealed that she would expect the medications to be administered at a set time frame of 5:00 AM through 6:00AM to avoid interference with breakfast.</p>	F 759		

WLR
11/25/21