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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415033	A. BUILDING _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHERWOOD REHABILITATION & HEALTH CARE CENTER	398 BELLEVUE AVENUE NEWPORT, RI 02840

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification Survey, was conducted from 9/11/2023 thru 9/13/2023 at Heatherwood Rehabilitation Health Care Center to determine compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities. State licensure and emergency preparedness surveys were also conducted at this facility. Deficiencies were cited as a result of this survey.	F 000	F 000 This plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. 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 all alleged violations are thoroughly investigated for 1 of 1 residents reviewed who was noted to have bruising to his/her genital area, Resident ID #85.	F 610	F 610 1. Residents ID's # 85 bruise was investigated an attributed to a fall. 2. All residents have the potential to be affected by the alleged deficient practice. The facility completed an audit of the 24- hour report which reviews all nursing progress notes to determine if there was any other resident identified with documented injuries of unknown cause. 3. The nurses received in-service education on the Abuse Policy and the reporting requirements of injuries of an unknown origin. The in-service also included when identifying any injury an immediate assessment to determine cause needs to be investigated and documented. The DNS or designee will audit any injury to determine if an origin was identified, documented, investigated and reported per protocol. 4. The results of the injury audits will be reviewed at the Quality Assurance Committee to ensure ongoing compliance. 5. The Director of Nursing is responsible for ensuring compliance.	10/4/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Simone Reeves — Administrator — 10/4/23

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 610	Continued From page 1 Findings are as follows: According to the State Operation Manual Appendix PP- Guidance to Surveyors for Long Term Care Facilities, last revised 2/3/2023 states in part, "...Possible indicators of physical abuse include an injury that is suspicious because the source of the injury is not observed, the extent or location of the injury is unusual...Examples of injuries that could indicate abuse include, but are not limited to...Bruises, including those found in unusual locations...The location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma)...Examples of Injuries of Unknown Source...Unobserved/Unexplained bruising or other injuries in the genital area..." Record review of the facility policy dated September 2020, titled, "ABUSE PROHIBITION POLICY," states in part, "...each resident has the right to be free from abuse...Any allegation of abuse will be thoroughly investigated...All alleged violations involving abuse...including injuries of unknown source...The Administrator, Director of Nursing or their designee assumes responsibility for...Ensuring that there is documentation in the resident's medical record of the incident, any interventions, physician and family notification at the time of the incident. Having evidence that all alleged violations are thoroughly investigated..." Record review revealed the resident was admitted to the facility in November of 2022 with a diagnosis including, but not limited to, Alzheimer's disease. Record review of a quarterly Minimum Data Set Assessment dated 8/17/2023 revealed the	F 610		

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F 610	Continued From page 2 resident's cognition was documented as severely impaired with short-and long-term memory problems. Further record review revealed a progress note dated 9/9/2023 at 7:28 PM, which indicates that a purple discoloration, bruise, was noted to the resident's genital area. During a surveyor interview on 9/11/2023 at 4:27 PM, with the Director of Nursing Services (DNS), when the surveyor asked if she was aware that the resident was noted with a bruise to his/her genital area on 9/9/2023, she stated, "sounds familiar." The DNS further indicated she would look for an incident report. Record review of documents provided by the DNS on 9/12/2023, the day after the surveyor inquired about the resident's bruise, revealed a document titled "SKIN TEAR/BRUISE INCIDENT REPORT & INVESTIGATION," which was signed by the DNS on 9/11/2023 and the Administrator on 9/12/2023. The investigation report included an undated document authored by the Supervisor, Licensed Practical Nurse, Staff A, which states in part, "...bruise of unknown origin found on 9/9/2023 Based on the presentation and coloring of area, it matches up with the time frame of the resident's fall on 9/3/2023." Record review of a progress note dated 9/3/2023 at 2:11 PM, revealed that the resident was found on the floor in another resident's room. The note states in part, "...Upon assessment there is no bruising or swelling, or gross abnormality present..." Record review of the facility document dated	F 610		

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F 610	Continued From page 3 9/3/2023 titled, "FALL INVESTIGATION," revealed that the resident was in another resident's room when s/he was found on the floor. The document also indicates that the other resident, Resident ID #62, reported that Resident ID #85 was on the floor and indicated s/he tripped. Additional record review of the facility's fall event document dated 9/3/2023 at 7:41 PM, indicates that the fall was unwitnessed. During a surveyor interview on 9/13/2023 at 9:11 AM with Nursing Assistant (NA) Staff B, she indicated that she worked on the unit on 9/3/2023 during the 7:00 AM - 3:00 PM shift. She further indicated the resident was found on the floor in another resident's room and she and another NA assisted the resident from the floor. Additionally, she indicated the resident was lying on the floor on his/her right side, fully clothed. Further record review of the facility's investigation file revealed that the NA who found the bruise to the resident's genital area on 9/9/2023 was not interviewed by the DNS until 9/11/2023 at 5:47 PM, after it was brought to the attention of the facility by the surveyor. Record review of a weekly skin audit completed on 9/6/2023 failed to reveal evidence that the resident had a bruise to his/her genital area. Record review failed to reveal evidence that any additional staff who provided care to the resident between 9/3/2023 through 9/9/2023 were interviewed or provided a statement for the investigation.	F 610		

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F 610	Continued From page 4 During a surveyor observation on 9/12/2023 at 3:42 PM, in the presence of NA Staff C, revealed an area approximately greater than 5 centimeters with purple and yellow discoloration to the resident's genital area. During a surveyor interview on 9/13/2023 at 5:04 PM with the DNS, she indicated that she is attributing the resident's bruise to the fall s/he sustained on 9/3/2023, which was 6 days prior to the bruise being identified. Additionally, she revealed that she had not begun her investigation into the origin of the resident's bruise until the surveyor brought it to her attention on 9/11/2023. Furthermore, she was unable to provide evidence that the incident was thoroughly investigated.	F 610		10/4/23
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to ensure that services provided meet professional standards of quality for 2 of 7 residents reviewed relative to physician orders, Resident ID #s 49 and 85. Findings are as follows: Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, "The physician is responsible for directing medical treatment. Nurses are obligated	F 658		10/4/23

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F 658	Continued From page 5 to follow physicians' orders unless they believe the orders are in error or would harm the clients." 1. Record review for Resident ID #49 revealed s/he was admitted to the facility in October of 2022 with diagnoses including, but not limited to, pain, history of venous thrombus (blood clot in the vein), spinal stenosis, and vertebral compression fractures. Record review revealed a physician's order dated 6/7/2023, which states "May have Palliative care consult for pain management." Record review revealed the palliative care consult was completed on 8/2/2023, indicating the consult was completed almost 2 months from the order date. Further review of the palliative care consult note indicated recommendations in part, which were reviewed and verified with the facility Physician Assistant (PA) on 8/3/2023: -Patient would like to have an evaluation by Physical Therapy (PT) and Occupational Therapy (OT) for strengthening. -Venous ultrasound of the bilateral lower extremities as the resident has a history of extensive deep vein thrombosis to the lower extremity. Record review revealed physician's orders for the following: -8/3/2023 for bilateral lower extremity venous ultrasound. -6/6/2023 to provide physical therapy/occupational therapy/speech evaluation	F 658	F 658 1. 1. Resident ID # 49 had the Palliative Consult completed as ordered. The Palliative nurse spoke directly to the nurse practitioner and reviewed the recommendations. The Nurse Practitioner did not agree with the recommendations and did not order the recommendations. The order on 6/6/2023 for "PT/ OT and ST evaluation when indicated" was an order entered on admission which appears in all residents' records. On 8/17/2023 resident ID # 49 refused therapy which was offered and documented. 2. All residents have the potential to be affected by the same alleged deficient practice. The facility ran an order summary report for the last 30 days to ensure any order entered was followed. 3. The licensed nursing staff received in-service training in the implementation of physician orders. The focus of the training emphasized Palliative Consults- when booking with hospice company ask how quickly consult can be performed, booking diagnostics and notification to the therapy department for any PT/OT or speech orders. The DNS or designee will review the new order listing report daily to audit follow thru on palliative consults, diagnostics and therapy orders. 4. The results of the order implementation audits will be reviewed at the Quality Assurance Committee to ensure ongoing compliance. 5. The Director of Nursing is responsible for ensuring compliance. 2. A. 1. Resident ID # 85 has had Senna added to [redacted] daily bowel regimen.	10/4/23

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F 658	Continued From page 6 when indicated. Further record review failed to reveal evidence that the above-mentioned orders were completed following the palliative care consult. During a surveyor interview on 9/13/2023 at 1:50 PM and again at 4:17 PM with the PA, she indicated that she would expect the palliative consult would have been completed within a month of the referral and that the ultrasound and the therapy evaluations would be completed as ordered. During a surveyor interview on 9/13/2023 at 2:34 PM and again at 4:03 PM with the Director of Nursing Services (DNS), she revealed that she would expect that the resident would have had the therapy evaluations and the ultrasound completed as ordered. 2 A. According to the facility policy, dated March 2016, titled, "Bowel Evacuation Protocol" states in part, " ...Procedure -If the resident has had no bowel movement [BM] for 9 consecutive shifts [3 days], begin the bowel protocol on the 3:00 p.m. - 11:00 p.m. shift. -The bowel protocol is to give Milk of Magnesia (MOM) on the 3:00 p.m. shift. If the MOM is ineffective, then the resident is to receive a Bisacodyl suppository on the 11:00 p.m. to 7:00 a.m. shift. If the Bisacodyl suppository is ineffective, then the resident is to receive a fleets enema on the 7:00 a.m. to 3:00 p.m. shift.	F 658	F 658 con't 2. All residents have the potential to be affected by the same alleged deficient practice. The facility will review the bowel summary report daily to identify residents to be placed on the bowel protocol according to days without moving their bowels. 10/4/23 3. The licensed nursing staff have received in-service training on the bowel protocol. The DNS or designee will audit the adherence to the protocol. 4. The results of the bowel protocol audits will be reviewed at the Quality Assurance Committee to ensure ongoing compliance. 5. The Director of Nursing is responsible for ensuring compliance. 2. B. 1. Resident ID # 85 has had orthostatic blood pressures taken. 2. All residents have the potential to be affected by the alleged deficient practice. A facility wide audit of residents with orders for orthostatic blood pressure monitoring was conducted to ensure blood pressure were taken as ordered. 3. The Licensed Nursing staff received in-service training on the following physician orders for orthostatic blood pressures. The DNS or designee will audit the MARs weekly to ensure any resident with orders for orthostatic blood pressure was completed. 4. The results of the orthostatic blood pressure audits will be reviewed at the Quality Assurance Committee to ensure ongoing compliance. 5. The Director of Nursing is responsible for ensuring compliance.	

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F 658	Continued From page 7 -Record the results of the Bowel Protocol... -Notify the physician if the Bowel Protocol is ineffective..." Record review for Resident ID #85 revealed s/he was admitted to the facility in November of 2022 with diagnoses including, but not limited to, Alzheimer's Disease and constipation. Record review revealed the following physician orders relative to the bowel protocol: -9/11/2023 for Milk of Magnesia (MOM) Suspension 400 Mg (milligrams)/5 ml (milliliters), 30 ml by mouth as needed (PRN) if no BM for 3 days. -11/11/2022 for Bisacodyl (Dulcolax) tablet, delayed release 5 mg by mouth once a day PRN for constipation. -11/11/2022 for Bisacodyl suppository 10 mg, rectally once a day PRN for constipation. -9/11/2023 for Fleet Enema 19-7 gram/118 ml, administer 1 rectally PRN. If no results from Dulcolax suppository give fleet enema on the 4th day. Record review of the resident's bowel record completed on 9/11/2023, revealed the resident had a bowel movement last documented on 9/3/2023, which indicated the resident did not have a BM in 7 days. Record review of the September 2023 Medication Administration Record (MAR), completed on 9/11/2023, failed to reveal evidence that the	F 658		

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F 658	Continued From page 8 bowel protocol was initiated. Additionally, record review of the resident's bowel record on 9/13/2023 revealed the resident had a BM on 9/13/2023 after s/he received the Dulcolax suppository. Subsequent record review completed on 9/13/2023, of the September 2023 MAR, revealed MOM was initiated on 9/11/2023 at 9:00 PM. Additionally, the record revealed the Dulcolax suppository was not administered until the following evening, at 8:55 PM. Lastly, the Fleet enema was never administered. Record review of the progress notes failed to reveal evidence that the provider was informed that the resident had not had a bowel movement since 9/3/2023. 2 B. Additional record review for Resident ID #85 revealed s/he was seen and assessed by psychiatric services on 8/17/2023 and 8/31/2023 with recommendations to increase his/her morning Risperdal to 1 mg and to obtain orthostatic blood pressures (a way to obtain blood pressures to determine if there is a drop in blood pressure during a change in the body's position from laying/sitting to standing) weekly for 4 weeks and discontinue if they are stable. Record review of the physician orders revealed an order with a start date of 8/17/2023 to obtain orthostatic blood pressures weekly for 4 weeks once a day on Mondays and to discontinue if they are stable. Record review of the August and September 2023 MARs failed to reveal evidence that the	F 658		

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F 658	Continued From page 9 orthostatic blood pressures were obtained on 8/21/2023, 8/28/2023, 9/4/2023 and 9/11/2023 as ordered. During a surveyor interview on 9/13/2023 at 1:25 PM with the DNS, she revealed that she would expect the bowel protocol to be followed and that the medications be administered if the resident did not have a bowel movement in 3 days. Additionally, the DNS revealed she would expect that the orthostatic blood pressures be obtained as ordered.	F 658		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. 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 necessary treatment and services, consistent with professional standards of practice, to promote wound healing and prevent new ulcers from developing for 2 of 5 residents reviewed with pressure ulcers (a	F 686		

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F 686	Continued From page 11 revealed a concern for actual alteration in skin integrity, which indicated a deep tissue injury (DTI - Purple or maroon area of discolored intact skin due to damage of underlying soft tissue) to the resident's right heel with a date of 8/29/2023. Interventions include, but are not limited to, skin prep to heels as ordered and an offloading boot order, already in place. Further review of the care plan did not identify any additional pressure areas. Review of a weekly skin audit, signed and dated by Licensed Practical Nurse (LPN), Staff D on 8/26/2023 indicated the resident had a "darkly pigmented stage one of right heel noted non-blanchable [stage I-discoloration of the skin that does not turn white when pressed]. R [right] side next to small toe reddened stage one. Booties in place." Further record review of subsequent skin evaluations failed to reveal evidence of the resident's reddened, non-blanchable area next to the small toe that was initially identified on 8/26/2023. Record review revealed the following physician's orders relative to the treatments to the resident's lower extremities: -8/28/2023 Skin Prep to bilateral heels twice daily. -7/5/2023 Wear offloading boots at night as tolerated to help reduce pressure to heels bilaterally twice daily. Further record review failed to reveal evidence that a treatment order was implemented for the Stage I pressure ulcer to the side of the resident's	F 686	F 686 con't A facility wide audit of residents on air mattress was completed to ensure the settings were appropriate. 3. The Licensed Nursing staff have received in-service training on ensuring the air mattresses are checked for functioning and setting as ordered. The wound nurse will complete air mattress audits to ensure they are functioning and at the proper settings. 4. The results of the air mattress audits will be reviewed at the Quality Assurance Committee to ensure ongoing compliance. 5. The Director of Nursing is responsible for ensuring compliance.	10/4/23

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F 686	Continued From page 12 right foot adjacent to his/her small toe, which was identified on 8/26/2023. During a surveyor observation with Nursing Assistant, Staff B on 9/13/2023 at 9:06 AM, revealed a dark discolored area to the resident's right heel. Additionally, two darkened areas were observed, one to the lateral (outer) side of his/her right foot next to the 5th toe, which was maroon in color and another area below that, which was blackened. During a surveyor telephone interview on 9/13/2023 at 10:42 AM with Staff D, the nurse who first identified the non-blanchable wound to the side of the resident's right foot, she revealed that she worked yesterday (9/12) and applied the skin prep to all areas of the resident's right foot, which included the heel and the other two areas near the 5th toe. Additionally, she stated, "We are treating both areas." During a surveyor observation on 9/13/2023 at 2:34 PM with the Wound Physician and the facility's Wound Nurse, revealed the existing DTI to the resident's right heel, the lateral side of his/her right foot was black in color and there was an additional area between the 4th and 5th toe that had depth. During a subsequent interview on 9/13/2023 at 2:47 PM with the Wound Physician, she revealed that prior to today, she did not observe any additional areas opened or closed to the resident's right foot. Additionally, she revealed that she would expect the nurses to notify her or the facility Wound Nurse of new wounds. Record review of the resident's weekly wound	F 686		

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F 686	Continued From page 10 localized injury to the skin and/or underlying skin usually over a boney prominence), Resident ID #s 37 and 73. Findings are as follows: Record review of the facility policy dated 7/2017 and titled, "Prevention & Management of Pressure Injuries" states in part, "Standard...The necessary treatment and services will be provided to promote healing, prevent infection, and prevent new pressure injuries from developing. POLICY: Residents with pressure injuries and those at risk for skin breakdown are identified, assessed, and provided appropriate treatment to encourage healing and/or maintenance of skin integrity. Ongoing monitoring and evaluation are provided... PROTOCOL: Assessment: Ulcer/Risk Factors...3. The resident's skin is observed daily with care. 4. Residents will have a weekly body audit completed by licensed staff. 5. Pressure injuries are assessed and documented on at least weekly and with a significant change in wound until it is resolved. Pressure injury assessment includes: Location, measurement...Stage, Presence of tunneling or undermining, Drainage Amount, Drainage Color, Odor...Appearance of wound bed, Appearance of wound edges, Appearance of peri wound...Wound Treatments are done per MD order." 1. Record review revealed Resident ID #37 was admitted to the facility in October of 2014 with diagnoses including, but not limited to, peripheral vascular disease and history of deep vein thrombosis (blood clot). Record review of the Pressure Ulcer Care Plan	F 686	F 686 10/4/23 1. 1. Resident ID #37 has a treatment in place and has been followed by the wound nurse and the Wound Doctor from Wound Specialists Company weekly and has healed at the time of writing this document. 2. All residents have the potential to be affected by the alleged deficient practice. A facility wide audit of all residents' feet has been completed to identify potential areas in need of treatment. 3. The Licensed Nursing staff received in-service on the wound care management policy. An emphasis on identification and implementation of treatment was part of the training. Immediate notification to the wound nurse for guidance was also reviewed with the licensed nursing staff. The wound nurse will audit the weekly skin checks to audit for any new areas identified and audit to determine appropriate treatment is in place. 4. The results of the skin check /treatment audits will be reviewed at the Quality Assurance Committee to ensure ongoing compliance. 5. The Director of Nursing is responsible for ensuring compliance. 2. 1. Resident ID # 73 has had the air mattress replaced with a system that can be set with the weight range not on a dial type setting. 2. All residents with air mattress have the potential to be affected by the alleged deficient practice. (The air mattress in sited deficiency was a type provided by hospice with a dial and was the only one of that type in the facility- there were 28 other air mattresses set appropriately on residents.)	

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F 686	Continued From page 13 description and measurements documented by the Wound Physician are as follows: -8/30/2023, "...Wound Assessment(s) Wound #1 Right Heel is a Deep Tissue Pressure Injury Persistent non-blanchable deep red, maroon or purple discoloration Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 5cm [centimeters] length x 5cm width x 0 cm depth...no drainage noted. Wound bed has 76-100% eschar [dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color]. The periwound skin texture is normal." -9/6/2023, "...Wound Assessment(s) Wound #1 Right Heel is a Deep Tissue Pressure Injury Persistent non-blanchable deep red, maroon or purple discoloration Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 5cm length x 5cm width x 0 cm depth...no drainage noted. Wound bed 76-100% eschar. There is no change in the wound progression. The periwound skin texture is normal." Additionally, the above-mentioned Wound Physician's assessments did not identify any other pressure injuries. During a surveyor interview on 9/13/2023 at 4:27 PM with the Minimum Data Set (MDS) Coordinator, she revealed that the resident's care plan, relative to the alteration in skin integrity, is updated from the Wound Physician's Documentation. During a surveyor interview with the Director of Nursing Services (DNS) on 9/13/2023 at 5:08	F 686		

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F 686	Continued From page 14 PM, she was unable to explain why a treatment order was not implemented for the pressure ulcers to the side of the resident's right foot when the wound was first identified. 2. Record review revealed Resident ID #73 was admitted to the facility in March of 2021 with diagnoses including, but not limited to, vascular dementia, stroke, and pressure ulcer of the right hip. Record review of an Annual Minimum Data Set (MDS) Assessment dated 8/19/2023 indicated the resident has an unstageable pressure ulcer (wound bed is covered by slough - non-viable yellow, tan, gray, green or brown tissue). Record review revealed a physician's order dated 8/17/2023, "May have Air Mattress for skin integrity. Check function and settings every shift." During a surveyor interview on 9/13/2023 at 3:30 PM with the DNS, she revealed the above-mentioned air mattress order indicates the mattress is checked to ensure that it is powered on and that the setting is per the resident's weight. During a surveyor observation on 9/11/2023 at 12:01 PM of the resident's air mattress pressure pump device revealed a piece, of masking tape, affixed to the left of the pump dial that adjusts the weight setting, with writing that reads, "set here." Further observation of the round dial revealed an arrow that pointed to the weight setting, indicating the setting was on 160-240 pounds. Subsequent observations of the resident's air mattress on 9/12/2023 at approximately 10:15	F 686		

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F 686	Continued From page 15 AM and again on 9/13/2023 at approximately 4:15 PM, revealed it remained set to the weight range of 160-240 pounds. Record review revealed the resident's most recent weight was 106.9 pounds. During surveyor observation and simultaneous interview on 9/13/2023 at approximately 4:20 PM with the DNS, Wound Nurse, and the resident's nurse, LPN, Staff E revealed the air mattress pump was on an incorrect setting of 160-240 pounds. They indicated the dial should have been set to the next weight range down. Additionally, Staff E revealed that she just goes into the resident's room and ensures that the air mattress pump is powered on and was unable to explain why the air mattress setting was not set to the correct weight range.	F 686		
F 687 SS=E	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that	F 687		

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F 687	Continued From page 16 the facility failed to ensure that the residents receive treatment relative to foot care for 2 of 8 residents observed, Resident ID #s 81 and 80. Findings are as follows: 1. Record review for Resident ID #81 revealed s/he was admitted to the facility in September of 2022 with a diagnosis that includes, but is not limited to, Parkinson's disease. Record review of a quarterly Minimum Data Set Assessment (MDS) dated 6/9/2023 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating his/her cognition is intact. Record review revealed a physician's order dated 1/31/2023 for podiatry services as needed (PRN). During a surveyor interview on 9/11/2023 at approximately 9:17 AM with the resident, s/he revealed that s/he would like to see a podiatrist to have his/her nails cut. During a surveyor observation of the resident's toenails on 9/12/2023 at approximately 3:30 PM revealed long, thickened, and discolored toenails, approximately 2 centimeters in length beyond the nail bed. Additionally, s/he revealed that s/he was experiencing discomfort related to the long toenails. Further record review failed to reveal evidence that podiatry services were received since his/her admission to the facility. During a surveyor interview on 9/12/2023 at 4:44 PM with Registered Nurse, Staff F, she was unable to provide evidence that the resident	F 687	F 687 10/4/23 1. Resident ID # 80 and 81 have been seen by a podiatrist on September 28, 2023. 2. All residents have the potential to be affected by the alleged deficient practice. A facility wide audit of the resident toenails was completed. A list of residents requiring podiatry care was created and provided the provider for podiatry care and are scheduled for September 27 and 28, 2023. 3. The social worker and nursing will work together to ensure all admissions are signed up for Health Drive to have podiatry services. The social worker and Licensed Nursing staff have received in-service education on Health Drive. The training had an emphasis on podiatry services. If for any reason the resident is not seen on the visit of the podiatrist, the DNS needs to be notified so alternative arrangements can be made. The DNS or designee will audit the podiatrist visits to ensure all residents in need of services were seen. 4. The results of the podiatrist visit audits will be reviewed at the Quality Assurance Committee to ensure ongoing compliance. 5. The Director of Nursing is responsible for ensuring compliance. EM 10/10/23	

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F 687	Continued From page 17 received podiatry services. During an additional surveyor observation of the resident on 9/13/2023 at 10:52 AM in the presence of the Director of Nursing Services (DNS), she acknowledged that the resident had long toenails as well as complaints of discomfort to his/her right great toe. She was unable to provide evidence that the resident had received podiatry services since s/he was admitted to the facility in September of 2022 . 2. Record review for Resident ID #80 revealed s/he was admitted to the facility in June 2021 with diagnoses including, but not limited to, left hemiplegia (weakness of the limbs), pressure induced deep tissue damage of the right heel and type 2 diabetes mellitus with hyperglycemia (high blood sugar). Record review of a Significant Change MDS Assessment dated 8/25/2023 revealed a BIMS score of 0 out of 15, indicating s/he has severe cognitive impairment. Record review revealed a physician's order dated 1/31/2023 for podiatry services as needed. During a surveyor observation of the resident's toenails on 9/13/2023 at 4:46 PM in the presence of the DNS, she acknowledged the resident's toenails to his/her left and right feet were long and thick extending beyond the nailbed. Additionally, the DNS obtained the following approximate measurements of the resident's toenails by using a measuring application on her cellular phone: Left foot:	F 687		

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F 687	Continued From page 18 - great toenail 1/2 inch (") in length - 2nd 1/4" in length - 3rd toe 1/2" in length - 4th 1/2" in length - 5th toe nail was 1/4" in length Right foot: - 3rd toenail 3/4" in length - 4th 1/4" in length - 5th toenail 1/2" in length Further record review failed to reveal evidence that the resident received podiatry services since his/her admission to the facility. During a surveyor interview on 9/13/2023 at 5:03 PM with the DNS, she was unable to provide evidence that the resident received podiatry services since s/he was admitted to the facility in June 2021.	F 687		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that each resident receives necessary respiratory care and services	F 695		

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F 695	Continued From page 19 that are in accordance with professional standards of practice for 1 of 5 residents reviewed for respiratory care, Resident ID #49. Findings are as follows: Record review revealed the resident was admitted to the facility in May of 2023 with a diagnosis including, but not limited to, stage four chronic obstructive pulmonary disease (a type of progressive lung disease characterized by long-term respiratory symptoms and airflow limitation). Surveyor observations of the resident on the following dates and times revealed s/he was receiving oxygen therapy via nasal cannula at 2 liters per minute: -9/11/2023 at 9:17 AM -9/12/2023 at 8:26 AM -9/12/2023 at 10:12 AM During a surveyor interview with the resident on 9/12/2023 at 10:12 AM s/he revealed that s/he has not been receiving oxygen therapy for very long, but that s/he does get out of breath sometimes. Record review failed to reveal evidence of a physician's order for oxygen therapy. During a surveyor interview on 9/12/2023 at 3:10 PM with Licensed Practical Nurse, Staff G, she was unable to provide evidence of an order for oxygen therapy.	F 695	F 695 1. Resident ID # 49 has an order for oxygen and oxygen saturation levels. 2. All residents requiring oxygen have the potential to be affected by the alleged deficient practice. A facility wide audit of residents receiving oxygen was completed to ensure if the oxygen order included a parameter for O2 saturations, that the saturations were documented as ordered. 3. The Licensed Nursing staff received in-service education on oxygen orders. If the physician order reads oxygen to maintain a certain saturation level an order for saturation levels must be entered for each shift. If a nurse implements oxygen as an urgent/ emergent nursing measure the physician needs to be called and an order for oxygen must be obtained as soon as possible. The DNS or designee will complete audits of the oxygen in the residents' rooms to ensure that there are orders in place for the oxygen and if appropriate oxygen saturation levels if ordered by the physician. 4. The results of the oxygen and saturation audits will be reviewed at the Quality Assurance Committee to ensure ongoing compliance. 5. The Director of Nursing is responsible for ensuring compliance.	10/4/23

em 10/10/23

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F 695	Continued From page 20 Record review of the physician orders on 9/13/2023, revealed an order was obtained on 9/12/2023 for "Supplemental oxygen at 1-2 liters/minute via nasal, cannula continuously, to maintain O2 sats [saturation] > [greater than] 90%..." Further record review failed to reveal evidence that the resident's oxygen saturation levels were monitored as ordered on 9/12/2023 and 9/13/2023. During a surveyor interview on 9/13/2023 at 1:50 PM with the resident's provider, she revealed she would expect the resident to have an order for oxygen therapy. Additionally, she would expect that the O2 saturation levels are documented at least daily to ensure the resident requires the oxygen. During a surveyor interview with the Director of Nursing Services on 9/13/2023 at 8:23 AM and again at 5:14 PM, she revealed she would expect that the resident would have an order for oxygen if s/he is receiving oxygen therapy. Additionally, she was unable to provide evidence of the oxygen saturation levels for 9/12/2023 and 9/13/2023.	F 695		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		

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F 761	Continued From page 21 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. 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 store and label drugs and biological's in accordance with currently accepted professional principles for 2 of 3 medication carts reviewed, and 2 of 3 medication rooms reviewed. Findings are as follows: Record review of an undated facility policy titled "Medication Storage" states in part, " ...Medications must be stored in accordance with manufacturer's specifications..." A. Medication Carts 1. During a surveyor observation on 9/12/2023 at 8:50 AM of the 3rd floor Medication Cart B, in the presence of Licensed Practical Nurse (LPN),	F 761	F 761 1. A. The medication carts- the 6 ampules were discarded. B. The medication rooms- the TB vial and the lovenox was discarded 2. The was no resident identified in this alleged deficient practice. The Guardian Consultant Pharmacy consultant did a facility wide medication storage assessment on September 22, 2023 to ensure dating and storage was appropriate. 3. The Licensed Nursing staff received in-service education on dating of vials when opened, dating of nebulizer ampules when foil pack is opened, and discarding or returning of discontinued medications to the pharmacy if appropriate. The DNS or designee will complete random audits of the medication carts and medication rooms to ensure dating and discarding of medication is appropriate. The pharmacy consultants will also complete medication storage audits monthly with their medication review. 4. The results of the Medication Room and Medication Cart audits will be reviewed at the Quality Assurance Committee to ensure ongoing compliance. 5. The Director of Nursing is responsible for ensuring compliance.	10/4/23

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F 761	Continued From page 22 Staff D, revealed the following: - One box of Budesonide 0.5 milligrams (mg)/2 milliliters (mL) ampule vial neb inhaler, containing 3 sealed foil envelopes and one single ampule in the box, not in the foil envelope and not labeled with a date. Manufacturer's guidance indicates store ampules in the foil envelope. Date once the foil envelope is opened and discard after 2 weeks. During a surveyor interview with Staff D immediately following the above-mentioned observation, she acknowledged that the above-mentioned medication was opened and not labeled with a date. 2. During a surveyor observation on 9/12/2023 at 9:03 AM of the 3rd floor Medication Cart A, with Certified Medication Technician, Staff H, revealed the following: - One box of Ipratropium-albuterol solution for nebulization 0.5 mg-3 mg/3 mL, containing sealed foil pouch and 5 ampules in the box, not in a foil pouch and not labeled with a date. Manufacture's guidance indicates, store unused solution in the foil pouch, may be stored outside of the pouch for up to 2 weeks. During a surveyor interview with Staff H, immediately following the above-mentioned observation, he acknowledged that the above-mentioned medication was opened with loose ampules in the box and not labeled with a date. B. Medication Rooms	F 761		

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	415033	A. BUILDING _____ B. WING _____	09/13/2023

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F 761	Continued From page 23 1. During a surveyor observation on 9/12/2023 at 8:46 AM of the 3rd floor medication room in the presence of Staff D, revealed the following: - One vial of Tuberculin solution, opened and not labeled with a date. Manufacturer's guidance indicates to date when opened then discard unused portion after 30 days. During a surveyor interview immediately following the above-mentioned observation with Staff D, she acknowledged that the Tuberculin solution was opened and not labeled with a date. 2. During a surveyor observation on 9/12/2023 at 9:38 AM of the 1st floor medication room in the presence of LPN Staff I, revealed the following: - One box containing approximately 5 pre-filled syringes of Lovenox 80 mg/0.8 mL, opened with an expiration date of 8/2023. During a surveyor interview with Staff I immediately following the above-mentioned observation, she acknowledged the medication was labeled with the expiration date of 8/2023. Additionally, she indicated that the cabinet the surveyor retrieved the medication from was located in the medication "over-flow cabinet," and that the resident who was prescribed the Lovenox had been discharged from the facility. Record review revealed the resident discharged from the facility in 2022. During a surveyor interview on 9/13/2023 at 1:42 PM, she indicated she would expect medications to be labeled with a date when opened and she would expect a discharged resident's medication	F 761		

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F 761	Continued From page 24 to be returned to the pharmacy.	F 761		
F 791 SS=E	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of	F 791	F 791 1. Resident ID # 49 was seen by the dentist on September 15, 2023 which was scheduled prior to annual survey process identifying resident request to be seen by the dentist. 2. All residents have the potential to be affected by the alleged deficient practice. A facility wide audit was completed to assess all resident to determine if any other resident has a dental need. 3. The Licensed Nursing staff have received in-service education on documentation of both the resident's need and booking of dental services. The DNS or designee will audit nursing report daily and any resident with documented dental needs will be followed up on to secure dental services. 4. The results of the dental care audits will be reviewed at the Quality Assurance Committee to ensure ongoing compliance. 5. The Director of Nursing is responsible for ensuring compliance.	10/4/23

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F 791	Continued From page 25 dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview it has been determined that the facility failed to provide or obtain from an outside resource, emergency dental services for 1 of 1 resident reviewed for dental pain, Resident ID #49. Findings are as follows: Record review revealed the resident was admitted to the facility in October of 2022 with diagnoses including, but not limited to, morbid obesity, other specified nutritional deficiencies, and protein calorie malnutrition (a deficit of protein). Record review of a Significant Change Minimum Data Set (MDS) Assessment dated 8/17/2023 revealed a Brief Interview for Mental Status (BIMS; an assessment tool used to evaluate a resident's cognitive function) score of 12 out of 15, indicating the resident has a moderate cognitive impairment. Further review of the MDS assessment revealed under section L, Oral/Dental status, that the resident was assessed to have obvious or likely cavities or broken natural teeth. Record review revealed a physician order dated 10/6/2022 for dental services as needed.	F 791		10/4/23

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F 791	Continued From page 26 Record review of the resident's progress notes reveal the following: -8/30/2023 at 8:12 AM "Resident with complaints of some oral discomfort related to dental status....suspected decay...Resident provided information on provider enrollment and signed agreement form to be seen by dental-podiatry-optometry as necessary. Signed form faxed back to provider this am [morning] and requested. resident be seen with upcoming visit if possible." -8/30/2023 at 2:01 PM risk management nutrition note, dental consult due to tooth pain discussed with nursing authored by the dietician -9/6/2023 at 11:47 AM risk management nutrition note, dental consult requested due to tooth pain authored by the facility dietician Record review failed to reveal evidence that dental services were provided to the resident after s/he complained of pain on 8/30 and 9/6/2023. During a surveyor interview on 9/12/2023 at 4:37 PM with the resident revealed his/her teeth "hurt sometimes." Additionally, s/he stated, "I have some that need to be pulled." During a surveyor interview on 9/13/2023 at 11:36 AM with the Director of Nursing Services, she was unable to provide evidence that the facility provided or obtained emergency dental services from an outside agency for Resident ID #49 after s/he began experiencing dental pain on 8/30/2023.	F 791		

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(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 the facility failed to ensure it stores, distributes, and serves food in accordance with professional standards for food safety relative to the main kitchen and 1 of 3 unit kitchenettes. Findings are as follows: 1. Review of Rhode Island Food Code, 2018 edition, section 3-501.17 states in part, "...refrigerated ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the	F 812	F 812 1. There were no residents identified in this alleged deficiency. 1. The items identified with no dates were discarded. 2. The food items identified on the 2nd floor nourishment refrigerator were discarded. 2. The food service director completed a facility wide audit of the kitchen and the nourishment refrigerators to ensure all items were dated in both the kitchen and the nourishment refrigerators. 3. The food service director in-serviced the dietary cooks on the policy of dating of all items withing the kitchen and following the policy of checking the nourishment refrigerators on the units daily and discarding any undated or unused food after 3 days. The food service director or designee will audit the kitchen for undated food items and audit the nourishment refrigerators on the nursing units to ensure all items are dated and discarded if unused after 3 days. 4. The results of the kitchen and nourishment refrigerator dating of food audits will be reviewed at the Quality Assurance Committee to ensure ongoing compliance. 5. The Food Service Director is responsible for ensuring compliance.	10/4/23

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F 812	Continued From page 28 premises, sold, or discarded when held at a temperature of 5 C [degrees Celsius] (41 F [degrees Fahrenheit]) or less for a maximum for 7 days. The date of preparation shall be counted as day 1..." During the initial tour of the main kitchen on 9/11/2023 at 8:50 AM, there were two, 6 inch by 6 inch pans underneath the prep counter. One was filled with white, viscous food matter and the other pan contained crumbled, white food matter. Both pans were observed to be covered in plastic wrap and were not labeled or dated. During a surveyor observation of the walk-in refrigerator during the initial tour on 9/11/2023 at approximately 9:00 AM, revealed the following: - A pan of ham salad dated 9/12 (one day ahead) - One small Styrofoam container containing unidentifiable food items, wrapped in plastic wrap, with no label or date During a surveyor interview with the Food Service Director (FSD) immediately following the above observations, he revealed he expects food to be labeled and dated the day it is prepared. He further acknowledged that the small 6 inch by 6 inch pans underneath the prep table contained bacon fat and roux and were not labeled and dated. Additionally, he revealed that they were discarded. 2. Record review of a policy titled, "Personal Food Policy," dated November 2016, states in part, "...4. The staff person receiving the personal food shall label the container with the date it was brought into the facility (or the date of preparation,	F 812		

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F 812	Continued From page 29 if known) and the name of the resident receiving it...8. Dietary aides are responsible for checking nourishment refrigerators daily and discarding any unused refrigerated foods after 3 days..." During a surveyor observation of the second-floor kitchenette on 9/11/2023 at 1:55 PM, revealed the following items were located in the refrigerator: - A Styrofoam container containing unidentifiable food items, dated 8/24/23 - A small rectangular blue Tupperware containing pasta salad, no name/date - A Cool Whip container containing unidentifiable food, dated 8/16 - A plastic takeout container with a sandwich and fries, no name/date - A Styrofoam container containing unidentifiable food items, dated 9/5 - A small 8 ounce soup container, dated 9/5 During a surveyor interview with Licensed Practical Nurse, Staff I, immediately following the above observation, she acknowledged that the above food items should have been discarded. During a surveyor interview with the FSD on 9/13/2023 at 11:20 AM, he revealed that he expects food brought in for the residents from outside of the facility to be labeled, dated, and discarded after 3 days per the facility's policy.	F 812		

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K 000	INITIAL COMMENTS The annual Federal Life Safety Code survey was conducted by the State Survey Agency. Heatherwood Rehabilitation and Healthcare Center was surveyed pursuant to the National Fire Protection Association 101 Life Safety Code, 2012 Edition as referenced in 42 CFR 483.90 (a - d) Physical Environment. Life Safety Code deficiencies were identified during the survey.	K 000	K 000 This plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on surveyor observations and staff interview, it has been determined that the	K 351	K 351 There was no resident identified in this deficiency. The Maintenance director and the surveyor conducted a facility wide audit of the sprinkler heads at the time of the survey. The facility has contracted with Johnson Controls for a quote to install the quick response sprinkle heads in the areas identified in the deficiency statement. The installation is scheduled to be completed upon Johnson Controls availability and delivery of supplies. Estimated completion date prior to October 24, 2023. Once completed there will be no need to continue to audit the sprinkler heads for appropriateness once the changes have been made.	

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OCT 04 2023
FACILITIES REGULATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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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K 351	Continued From page 1 sprinkler system or any of its components does not meet the requirements of installation in accordance with NFPA 101 Life Safety Code 2012 Edition section 9.6 and NFPA 13 Standard for the Installation of Sprinkler Systems 2010 Edition. This deficient practice has the potential to effect 95 of 95 residents as well as an indeterminable number of staff and visitors. Findings are as follows: Review of NFPA 13 Standard for the Installation of Sprinkler Systems 2010 Edition, section 8.3 states in part ..."8.3.3.2 Where quick-response sprinklers are installed, all sprinklers within a compartment shall be quick-response unless otherwise permitted in 8.3.3.3." Surveyor observations made during the life safety tour in the presence of the Maintenance Director on 9/12/2023, revealed that both stairwells, the third floor Long Hall unit, the second floor Long Hall unit and the second floor dining room have mixed sprinkler types consisting of standard response sprinklers and quick response sprinklers. During a surveyor interview with the Maintenance Director, on 9/12/2023 at 10:50 AM, he acknowledged that the above mentioned areas have mixed sprinkler types consisting of standard response sprinklers and quick response sprinklers.	K 351		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed,	K 355		

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K 355	Continued From page 2 inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 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 maintain the portable fire extinguishers in accordance with National Fire Protection Agency (NFPA) 101 Life Safety Code 2012 Edition section 19.3.5.12 and NFPA 10 Standard for Portable Fire Extinguishers 2010 Edition. This deficient practice has the potential to effect 95 of 95 residents, as well as an indeterminable number of staff and visitors. Findings are as follows: Review of NFPA 10 Standard for Portable Fire Extinguishers 2010 Edition states in part... "7.2 Inspection. 7.2.1 Frequency. 7.2.1.1* Fire extinguishers shall be manually inspected when initially placed in service. 7.2.1.2* Fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals... 7.2.4 Inspection Record Keeping. 7.2.4.1 Personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action... 7.2.4.3 Where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded.	K 355	K 355 All fire extinguishers in the facility have been visually inspected for the month of September and October 2023. A list of locations of all fire extinguishers was created by the maintenance department. Each month all extinguishers on the list will be visually inspected and checked off the control list. This control list will serve as a monthly audit of the visual fire extinguisher inspections required. The results of the fire extinguisher visual inspection audit will be submitted to the quality assurance committee to ensure ongoing compliance. The Maintenance Director is responsible is responsible for compliance.	10/4/23

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K 355	Continued From page 3 7.2.4.4 Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. 7.2.4.5 Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. 7.3* Maintenance. 7.3.1 Frequency. 7.3.1.1 All Fire Extinguishers. 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. 7.3.1.1.2 Fire extinguishers shall be internally examined at intervals not exceeding those specified in Table 7.3.1.1.2..." Surveyor observations made on 6/27/2023 in the presence of the Maintenance Director, revealed that the following fire extinguishers were not being visually inspected every 30 days as required: 1. Third floor by room 319 2. Third floor dining room 3. Third floor by room 313 4. Third floor by room 310 During a surveyor interview with the Maintenance Director on 9/12/2023 during the life safety tour, he was unable to provide evidence that the portable fire extinguishers were being maintained with visual inspection intervals of not more than 30 days as required.	K 355		
K 712 SS=F	Fire Drills	K 712		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 4 CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to provide evidence that fire drills were being conducted in accordance with the National Fire Protection Association (NFPA) 101 2012 Edition section 19.7.1. This deficient practice has the potential to effect 95 of 95 residents as well as an indeterminable number of staff and visitors. Findings are as follows: Review of NFPA 101 2012 edition chapter 19 Existing Health Care occupancies states in part, "...19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions." Review of the Centers for Medicare and Medicaid Services (CMS) regulations states in part, "...Fire drills are held at expected and unexpected times	K 712	K 712 There were no residents identified in this deficiency. The facility has scheduled fire drills at random times, one per month, on alternating shifts. September's drill was completed on September 30, 2023 on the 11-7 shift t 6:50am. The Maintenance Director will report the fire drills and shifts completed to the Quality Assurance Committee to ensure ongoing compliance. The maintenance Director is responsible for maintaining compliance.	10/4/23

em 10/10/23

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415033	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/12/2023

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K 712	Continued From page 5 under varying conditions, at least quarterly on each shift." Review of the facility's fire drill documentation on 9/12/2023, revealed that the required fire drills were not being conducted at varied times on all shifts. During a surveyor interview with the Maintenance Director on 9/12/2023 at 10:50 AM, he was unable to provide evidence that that the required fire drills were being conducted at varied times on all shifts.	K 712		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a	K 918	K 918 There were no residents identified in this deficiency. The facility has purchased the appropriate tool to complete the specific gravity readings on the generator batteries. The specific gravity reading was obtained for September and was 1260. The facility has completed a log to document the monthly specific gravity readings from the batteries of the generator. The results of the specific gravity readings for the generator batteries will be submitted to the Quality Assurance Committee to ensure ongoing compliance. The Maintenance Director is responsible for maintaining compliance.	10/4/23

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K 918	Continued From page 6 program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 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 the Emergency Power Supply System (EPSS) generator was being maintained in accordance with National Fire Protection Association (NFPA) 99 Health Care Facilities Code 2012 Edition, NFPA 101 Life Safety Code 2012 Edition, and NFPA 110 Standard for Emergency and Standby Power Systems 2010 Edition. This deficient practice has the potential to effect 95 of 95 residents, as well as an indeterminable number of staff and visitors. Findings are as follows: Review of the monthly maintenance records for the EPSS generator on 9/12/2023, revealed 12 out of 12 missed opportunities to obtain and document monthly specific gravity readings of the facility's emergency backup generator batteries. During a surveyor interview with the Maintenance Director on 9/12/2023 at 10:55 AM, he was unable to provide evidence that the monthly specific gravity readings of the facility's	K 918		

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K 918	Continued From page 7 emergency backup generator batteries had been obtained and documented, as required.	K 918		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders	K 923	K 923 There were no residents identified in this deficiency statement. The Oxygen tank was placed in a stand and removed from the medication room. The surveyor and Maintenance Director did a facility wide audit at the time of survey and no other oxygen issues were identified. The Licensed nursing staff received in-service education on the proper storage of oxygen. The DNS or designee will randomly audit the medication rooms to ensure there is no oxygen being stored in them. The results of the oxygen stored in medication room audits will be submitted to the quality assurance committee to ensure ongoing compliance. The Maintenance Director is responsible for maintaining compliance.	10/4/23

em 10/10/23

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K 923	Continued From page 8 are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined that the facility failed to maintain oxygen cylinders in accordance with National Fire Protection Association (NFPA) 99 2012 edition sections 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5. This deficient practice has the potential to effect 95 of 95 residents, and an undetermined number of staff and visitors. Findings are as follows: Review of NFPA 99 2012 edition states in part, "11.3.2* Storage for nonflammable gases greater than 8.5 m3 (300 ft3), but less than 85 m3 (3000 ft3), at STP shall comply with the requirements in 11.3.2.1 through 11.3.2.3... 11.3.2.6 Cylinder or container restraints shall comply with 11.6.2.3... 11.6.2.3 Cylinders shall be protected from damage by means of the following specific procedures: (1) Oxygen cylinders shall be protected from abnormal mechanical shock, which is liable to damage the cylinder, valve, or safety device. (2) Oxygen cylinders shall not be stored near elevators or gangways or in locations where heavy moving objects will strike them or fall on them. (3) Cylinders shall be protected from tampering by unauthorized individuals. (4) Cylinders or cylinder valves shall not be repaired, painted, or altered. (5) Safety relief devices in valves or cylinders shall not be tampered with.	K 923		

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K 923	Continued From page 9 (6) Valve outlets clogged with ice shall be thawed with warm- not boiling - water. (7) A torch flame shall not be permitted, under any circumstances, to come in contact with a cylinder, cylinder valve, or safety device. (8) Sparks and flame shall be kept away from cylinders. (9) Even if they are considered to be empty, cylinders shall not be used as rollers, supports, or for any purpose other than that for which the supplier intended them. (10) Large cylinders (exceeding size E) and containers larger than 45 kg (100 lb) weight shall be transported on a proper hand truck or cart complying with 11.4.3.1. (11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. (12) Cylinders shall not be supported by radiators, steam pipes, or heat ducts..." Surveyor observations of the third floor medication storage room on 9/12/2023 at 8:46 AM, revealed one oxygen cylinder unsecured laying on its side on top of a cardboard box. During a surveyor interview with Licensed Practical Nurse, Staff D, she indicated that the spare oxygen cylinders should be stored on the first floor and not in the medication room on top of a cardboard box. During a surveyor interview with the Administrator and the Director of Nurses on 9/12/2023 at 4:39 PM, they indicated that spare oxygen cylinders should be stored in the holders on the first floor and not in the medication room.	K 923		