

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

PRINTED: 08/04/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2021
NAME OF PROVIDER OR SUPPLIER WEST VIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 239 LEGRIS AVENUE WEST WARWICK, RI 02893		
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F 000	INITIAL COMMENTS A Recertification Survey was conducted at West View Nursing and Rehabilitation Center from 07/26/2021 through 07/29/2021 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, deficiencies were identified.	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550 8/19/21 ML	The filing of this Plan of Correction (POC) does not constitute that the deficiencies alleged did in fact exist, rather this POC is filed as evidence of the facility's continuing commitment to high quality resident care in full compliance with state and federal regulations. In-services have been underway and are ongoing. We are alleging compliance effective August 28, 2021. As a Plan of Correction (POC) for Tag F550: a) Resident ID#20 had his/her needs addressed as soon as possible on the date in question on the 2567. A female CNA was not readily available due to caring for other residents at the time of ID#20's request. We have spoken with the male staff member regarding the interaction between him and Resident ID #20. We have also spoke with Resident ID#20 to ensure he/she is understanding of the situation on that day. b) We have since reviewed all residents who have requested female caregivers (only) to ensure care plans are current and that staff are aware of who those residents are.		

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

TITLE

Administrator

(X6) DATE

8/18/21

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 550	<p>Continued From page 1</p> <p>rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>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 treat each resident with respect and dignity in an environment that promotes maintenance of his or her quality of life for 1 of 19 residents reviewed, Resident ID #20.</p> <p>Findings are as follows:</p> <p>Resident ID #20 was admitted to the facility in September of 2020 with diagnoses that include, but are not limited to, dementia, difficulty in walking and unsteadiness on feet. Record review of a quarterly Minimum Data Set assessment revealed the resident has mild cognitive impairment and is occasionally incontinent of urine. Further review of a plan of care initiated on 9/13/2020 revealed the resident was at risk for falls with an intervention to assist with toileting as needed.</p> <p>During a surveyor observation on 7/27/2021 at 7:48 AM, the surveyor observed the call light on</p>	F 550	<p>c) There is a blackboard in the Nurses' station (staff report area) on each unit; this blackboard indicates specific care needs and other related information that staff need to be aware of each shift. We will include those residents who request female caregivers only on this blackboard for easy viewing and awareness of staff. We have (re) educated staff about the importance of viewing these blackboards and they have been empowered to add any important information (care needs) to the blackboards.</p> <p>d) The nursing management team will monitor this situation for assurances that resident requests such as this, is being carried out. Audits and observations will be done routinely, and findings shared with the QAPI Committee. The QAPI Committee will confirm completion no less than monthly for at least 3 months, after which time, the Committee will re-evaluate the need to formally monitor the issue based on our level of compliance.</p>		

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F 550	Continued From page 2 outside the resident's room and the resident calling out for help. Nurse, Staff A, entered the room. The resident was requesting help to go to the bathroom, but refused help from Staff A stating, "I don't want you; I don't want a man helping me." Staff A proceeded to tell the resident to urinate in his/her brief and left the room to answer another call light. The resident continued to call out for help. Staff A entered the room again and told the resident the nurse assistant (NA) was busy with another resident and was unavailable to help him/her. During an interview with Staff A, following the observation, he revealed the resident was continent of urine and that the NA was assisting another resident in the shower. He further acknowledged that he told the resident s/he could urinate in his/her brief. The NA arrived to the room during the interview and was able to tend the resident's needs. During an interview with the Quality Improvement Nurse on 7/28/2021 at 2:06 PM, she stated she would have expected Staff A to find a female staff to tend to the resident while the primary NA was unavailable.	F 550			
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose	F 561			

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F 561	<p>Continued From page 3</p> <p>activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.</p> <p>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.</p> <p>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, it has been determined that the facility failed to promote and facilitate resident self-determination through support of resident choice about aspects of his or her life in the facility that are significant to the resident for 1 of 2 residents reviewed for choices, Resident ID #80.</p> <p>Findings are as follows:</p> <p>Resident ID #80 was admitted to the facility in March of 2016 with diagnoses that include, but are not limited to, dysthymic disorder (a depressive mood disorder), anxiety and arthritis.</p> <p>Record review of an annual Minimum Data Set assessment dated 6/22/2021 revealed the</p>	F 561 <i>MLL</i> <i>8/19/21</i>	<p>As a POC for Tag F561:</p> <p>a) Resident ID# 80 has since had showers routinely.</p> <p>b) We have since reviewed all residents shower schedule to ensure showering/bathing is getting done accordingly and per resident request. We did not identify any further concerns associated with this issue.</p> <p>c) Upon further investigation of this allegation, we did identify that the showers, in fact, had been given but the issue was they were not documented accordingly. We are re-educating our nursing staff of the required and proper documentation of showers/baths to ensure evidence that they were done. In the event a resident declines a shower/bath, staff will also document that accordingly. Any ongoing refusals will be reviewed by the nursing management team/designee for follow-up.</p> <p>d) The Director of Nursing (DNS)/designee is responsible to implement this plan. We have devised an audit tool to ensure compliance with the plan for showering and documentation. The plan and results of the audits will be shared with the QAPI committee monthly for no less than 3 months. After a 3-month period of time, the Committee will determine the need to continue the audits based on our level of improvement and compliance with the improvement plan. Changes will be made to our plan as needed to ensure compliance.</p>	

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F 561	Continued From page 4 resident was cognitively intact, that it was very important for him/her to choose between a bath/shower and s/he required physical help of one person for bathing. During an interview with the resident on 7/29/2021 at 8:43 AM, it was revealed that s/he had not had a shower in 2-3 weeks. S/he further stated s/he usually had a shower once a week and had not been offered a shower in quite some time. S/he went on to state the last time s/he asked for one, s/he was rushed and was afraid to ask for a shower again. Record review of the Point Click Care task documentation revealed the last shower that was documented was on 7/7/2021, which was 3 weeks ago. During an interview on 7/29/2021 at 9:12 AM with the nursing assistant (NA), Staff B, she revealed the NAs check the assignment to see who is due for a shower and if the resident refuses, there is an option to document refusals. Review of the NA assignment sheet revealed the resident's shower days are Monday and Thursday on the evening shift. During an interview on 7/29/2021 at 11:39 AM with the Assistant Director of Nursing, she failed to provide evidence that the resident had received a shower since 7/7/2021.	F 561			
F 578 SS=D	Request/Refuse/Dscntnue Trmnt; Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to	F 578	<p><i>WNR</i> <i>8/11/21</i></p> <p>As a POC for Tag F578:</p> <ul style="list-style-type: none"> a) The Advance Directive forms and orders for Resident ID#292 has since been corrected. Resident ID#298 is no longer at the facility. b) We have since reviewed all residents' Advance Directives and orders to ensure the information is correct and matches. We will continue to monitor this carefully. c) Upon further investigation of this issue, we noted that it seemed to be an issue upon readmission to our facility; there were occasions when code status was changed during hospitalization. Therefore, our internal processes of checking this upon readmission to our facility have been improved to ensure the Advance Directives and orders are 		

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F 578	<p>Continued From page 6</p> <p>been determined that the facility failed to ensure that the residents' formulated advance directive would be followed as there was inconsistency between the paper medical record and the Electronic Medical Record (EMR) for 2 of 24 residents reviewed for Advance Directives, Resident ID #s 292 and 298.</p> <p>Findings are as follows:</p> <p>Review of the facility policy titled "Advance Directives" states in part:</p> <p>"4. ...If the resident has an advance directive already in place, a copy is to be placed in the resident's medical record...</p> <p>6. The charge nurse is responsible to review the information upon the resident's admission to the unit...</p> <p>7. In the absence of a specified code status, or/and advance directive, the resident is to be considered a full code...</p> <p>8. Once the resident or responsible party has indicated the preferred code status and has signed the form, the signed form is to be placed in the Physician's Order section..."</p> <p>1. Review of the signed advance directive for Resident ID #292 revealed an advance directive of attempt resuscitation/CPR (cardiopulmonary resuscitation), dated 7/18/2021. Further record review revealed a physician's order for Do Not Resuscitate (DNR) dated 7/18/2021.</p> <p>During a surveyor interview on 7/28/2021 at 10:12 AM with Resident ID #292, s/he stated s/he does</p>	F 578			

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F 578	Continued From page 7 not want to be a full code. During a surveyor interview on 7/28/2021 at 1:57 PM with nurse Staff C, she revealed in the event of a resident becoming unresponsive, she would refer to the signed advance directive which indicates to attempt resuscitation. Additionally, she was unable to explain why the signed advance directive and the order did not match. 2. Review of the medical record for Resident ID #298 revealed a signed advance directive of DNR dated 7/21/2021. Further record review on 7/28/2021 at 8:35 AM failed to reveal evidence of a physician's order in the electronic medical record. During a surveyor interview on 7/28/2021 at 2:10 PM with the Assistant Director of Nursing Services, she acknowledged that there was no advance directive order until it was brought to her attention by the surveyor.	F 578			
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident	F 655			

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F 655	<p>Continued From page 8 including, but not limited to-</p> <p>(A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.</p> <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <p>(i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to revise the baseline care plan for 2 of 5 sample residents, Resident ID #s 293 and 298.</p> <p>Findings are as follows:</p> <p>1. Record review for Resident ID #293 revealed</p>	F 655	<p>As a POC for Tag F655:</p> <p>a) Resident ID#298 is no longer residing at the facility. The care plan and safe patient handling status has since been clarified for Resident ID#293. There were no negative outcomes associated with the items mentioned by the surveyors.</p> <p>b) We have since reviewed all residents' baseline care plans to ensure accuracy of information.</p> <p>c) Because the baseline care plan must be done within 48 hours of admission, there are occasions when the information is, in fact, accurate for those first 48 hours but then may change quickly as the residents' condition changes during their stay; we will be focusing our improvement strategy accordingly. The nursing management and MDS teams will review the care plans timely to ensure accuracy of information. The care plans will be reviewed at the first Risk meeting and then routinely thereafter when there are changes in condition (to be added to the plan of care).</p> <p>d) The DNS/designee is responsible to implement this plan. We have devised an audit tool to ensure compliance with appropriate care plan revisions. The plan and results of the audits will be shared with the QAPI committee monthly for no less than 3 months. After a 3-month period of time, the Committee will determine the need to continue the audits based on our level of</p>		

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F 655	Continued From page 9 the resident has a baseline care plan initiated on 7/14/2021 for "Safe Patient Handling [SPH]." Interventions include, but are not limited to, "SPH: Resident is requiring a Hoyer lift [mechanical lift]..." During a surveyor interview on 7/28/2021 at 10:23 AM with the certified occupational therapy assistant, Staff D, she revealed the resident requires a contact guard assistance for transferring, not a Hoyer lift. During an interview with the Minimum Data Set (MDS) nurse, Staff E, on 7/29/2021 at 11:46 AM, she was unable to provide evidence that the resident requires a Hoyer lift for transfer. 2. Record review revealed Resident ID #298 has a baseline care plan initiated on 7/21/2021 for "The resident is at risk for falls..." Interventions include, but are not limited to, "Floor mat to side of bed" Surveyor observations revealed the mat was not on the floor, at the side of the bed, while the resident was in bed, on the following dates and times: -7/26/2021 at 10:00 AM, 12:03 PM, and 1:55 PM -7/27/2021 at 9:50 AM and 12:26 PM -7/28/2021 at 11:30 AM -7/29/2021 at 10:00 AM During a surveyor interview with the MDS Nurse, Staff E, on 7/29/2021 at 11:23 AM, she acknowledged that the care plan had an intervention for a floor mat to the side of the bed.	F 655	improvement and compliance with the improvement plan. Changes will be made to our plan as needed to ensure compliance.		
F 657 SS=D	Care Plan Timing and Revision	F 657			

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F 657	Continued From page 10 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. 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 comprehensive care plan was revised by the interdisciplinary team after each assessment, for 2 of 19 residents, Resident ID #'s 21 and 55. Findings are as follows:	F 657 <i>MR</i> <i>8/14/21</i>	As a POC for Tag F657: a) Residents ID#21 and ID#55 have since had their care plan updated to reflect current status and condition. b) We have since reviewed all residents' care plans to ensure accuracy of the plan of care and timely updates. c) The nursing management and MDS teams will review the care plans timely to ensure accuracy of information. The care plans will be reviewed at the ongoing Risk meetings and then routinely thereafter when there are changes in condition (to be added to the plan of care). d) The DNS/designee is responsible to implement this plan. We have devised an audit tool to ensure compliance with appropriate care plan revisions. The plan and results of the audits will be shared with the QAPI committee monthly for no less than 3 months. After a 3-month period of time, the Committee will determine the need to continue the audits based on our level of improvement and compliance with the improvement plan. Changes will be made to our plan as needed to ensure compliance.	

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F 657	<p>Continued From page 12</p> <p>2. Record review revealed Resident ID #55 was admitted to the facility in September 2020 with diagnoses that include, but are not limited to, dysphagia (difficulty swallowing) and pneumonia.</p> <p>Record review of the plan of care revealed a focus area dated 10/12/2020 of impaired physical mobility with an intervention stating resident has upper dentures, assist with oral care as needed, ensure resident is wearing denture for meals.</p> <p>During an interview with the resident on 7/26/2021 at 9:19 AM, s/he revealed his/her dentures had fallen out of his/her mouth in December of 2020 and were broken. Surveyor observation at the time of the interview revealed the resident did not have dentures.</p> <p>During an interview on 7/28/2021 at 12:21 PM with nursing assistant, Staff F, during lunch, she stated, "yes [the resident] does have dentures, they were too big...they were being repaired unless [s/he] hasn't gotten them back." Staff F checked the residents bedside table and could not find any dentures. She then asked the resident and s/he stated they were sent out and can't be fixed.</p> <p>During an interview with the social worker, Staff G, on 7/29/2021 at 10:04 AM, he provided documentation that the resident's dentures had been sent out for repair in February of 2021, but the dentist was unable to repair them.</p> <p>During an interview with the resident's daughter on 7/29/2021 at 1:45 PM, she revealed the resident's dentures were broken and s/he had not had them since December 2020.</p>	F 657 <i>WR</i> <i>8/14/21</i>		

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F 657	Continued From page 13 During an interview with the MDS nurse, Staff E, on 7/29/2021 at 11:18 AM, she acknowledged the intervention regarding the resident's dentures should have been reviewed and revised to reflect the resident's current status.	F 657			
F 658 SS=D	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 the services provided by the facility meet professional standards of quality relative to oxygen tubing for 2 of 2 residents reviewed for oxygen, Resident ID #s 13 and 391, and 1 of 1 resident reviewed for PICC (peripherally inserted central catheter) line care, Resident ID #298. Findings are as follows: A. According to the facility policy titled, "Oxygen Administration," under the heading "Maintenance of Equipment" states in part, "...2. Check and clean all equipment as needed and at least weekly. 3. Masks, cannulas and tubing are to be changed as needed and at least weekly..." 1. Resident ID #13 was admitted to the facility in April of 2021 with diagnoses including, but not limited to, atrial fibrillation (a rapid, irregular heart rhythm), aortic valve stenosis (narrowing of the valve in the vessel of the heart), and asthma (an	F 658 <i>WR</i> <i>8/19/21</i>	As a POC for Tag F 658: a) Residents ID#13 and ID#391 did not have any negative outcome associated with tubings not being changed routinely. ID#298 is no longer at the facility however, this resident did not have any negative outcome associated with PICC line care. b) We have since reviewed all residents using oxygen and any resident with a PICC line for assurances that professional standards are being followed. We have not identified any further issues of concern. c) We have provided education to the nurses related to the importance of changing the oxygen tubings routinely as well as care for any PICC lines/dressings or other related clinical services. We have reviewed the policy on PICC line care with the nurses and we will monitor these two areas carefully as part of our QAPI Plan.		

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F 658	<p>Continued From page 14 inflammatory disease of the airways of the lungs).</p> <p>During a surveyor observation on 7/28/2021 at 9:38 AM, the resident was observed receiving oxygen therapy via nasal cannula. The nasal cannula tubing was observed with a date of 7/8/2021, revealing the tubing had not been changed in 3 weeks.</p> <p>Record review of the resident's Treatment Administration Record (TAR) failed to reveal a physician's order to change the oxygen tubing weekly.</p> <p>2. Resident ID #391 was admitted to the facility in July of 2021 with diagnoses including, but not limited to, chronic obstructive pulmonary disorder (chronic inflammatory lung disease) and atherosclerotic heart disease of the native coronary artery (narrowing of the arteries).</p> <p>During a surveyor observation on 7/28/2021 at 8:27 AM, the resident was observed receiving oxygen therapy via nasal cannula. The nasal cannula tubing was observed with a date of 6/22/2021.</p> <p>During a surveyor interview on 7/28/2021 at 2:10 PM with the Assistant Director of Nursing Services, she acknowledged the oxygen tubing dates for both residents as stated above and that the tubing was not changed weekly.</p> <p>B. According to Infusion Nursing Standards of Practice, 2011:</p> <p>"Standard 10- Orders for the initiation and management of infusion therapy. Standard 10.1 Infusion therapy should be initiated, changed, or</p>	F 658	<p>d) The DNS/designee is responsible for implementation of this plan. Routine auditing of these areas will be done to ensure compliance. The plan and audits will be reviewed by the QAPI committee no less than monthly for the next 3 months after which time, the Committee will determine the need to continue the formal audits based on our level of compliance. If necessary, the plan will be revised as needed to ensure compliance.</p> <p><i>ur</i> <i>8/19/21</i></p>	

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F 658	<p>Continued From page 15 discontinued upon the order of a licensed independent practitioner (LIP)."</p> <p>According to the facility policy, titled PICC line dressing protocol, which states in part, "...1. Dressing change must be done 24/hrs after initial placement and then weekly...5...During all dressing changes assess the external length of the catheter to determine if migration of the catheter has occurred. Notify Physician if measurements do not match initial measurements..."</p> <p>Resident ID #298 was admitted to the facility in July of 2021 with a PICC line (an intravenous access device) in place to receive antibiotic therapy. The resident's medical diagnoses include, but are not limited to, urinary tract infection, sepsis (the body's systemic response to an infection), and ESBL (Extended Spectrum Beta Lactamase-an enzyme producing bacteria).</p> <p>Record review of the July 2021 Medication Administration Record (MAR) on 7/27/2021 at approximately 2:30 PM failed to reveal a physician's order for PICC line flushes and weekly dressing changes with measurements.</p> <p>Additionally, record review failed to reveal measurements of the external catheter.</p> <p>During a surveyor interview on 7/29/2021 at 12:48 PM with Staff nurse C, she acknowledged from the time of the resident's admission to 7/28/2021 there was no orders for PICC line flushes or weekly dressing changes. Additionally, she stated that she changed the dressing to the PICC line on 7/28/2021, and she did not obtain measurements of the external catheter.</p>	F 658			

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F 679 SS=E	<p>Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)</p> <p>§483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on surveyor record review, staff and family interview, it has been determined that the facility failed to provide an ongoing program to support a resident in their choice of activities, designed to meet the interests of and support the well-being of each resident, based on the comprehensive assessment, care plan, and preferences of each resident for 1 of 3 residents reviewed for activities, Resident ID #67.</p> <p>Findings are as follows:</p> <p>Review of the facility policy titled, "Activity Program," states in part, "It is the policy of this facility to provide an on-going program of facility sponsored group, individual and independent activities and leisure time pursuits based on each resident's comprehensive assessment, plan of care, preferences, and choice. Activities will be designed to meet resident interest and to promote physical, mental and psychosocial well-being."</p> <p>Record review revealed that the resident was last</p>	F 679 <i>WV</i> <i>8/19/21</i>	<p>As a POC for Tag F679:</p> <p>a) Resident ID#67 has since been revisited by the Activity department for assurances that needs are being met in this area. The issue noted by surveyors was actually one of documentation rather than the resident's plan of care not being met.</p> <p>b) We have since reviewed those residents who participate in Activities as a 1:1 visit for assurances that assessed needs and preferences are being met and that the visits are documented accordingly.</p> <p>c) The Activity Department is re-educating their team to ensure residents assessed needs and preferences are care planned accordingly and their activity plan created based on those assessments. We are also assuring that there is documented evidence of the 1:1 visits.</p> <p>d) The Activity Director/designee is responsible for implementation of this plan. An audit has been devised to ensure compliance. The plan and audits will be reviewed by the QAPI committee no less than for the next 3 months after which time, the Committee will determine the need to continue the formal audits based on our level of compliance. If necessary, the plan will be revised as needed to ensure compliance.</p>		

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F 679	<p>Continued From page 17</p> <p>admitted to the facility in February of 2018 and has diagnoses which include, but are not limited to, Alzheimer's disease, borderline personality disorder, anxiety disorder, cognitive communication deficit, and major depressive disorder.</p> <p>Review of the Minimum Data Set assessment, dated 6/17/2021, revealed that the resident has severe cognitive impairment.</p> <p>Review of the Activity Participation Review, dated 5/12/2021, revealed that the resident "likes to socialize with others, but only in [his/her] room." It further indicates that staff will visit with the resident for one on one activities.</p> <p>Review of the care plan, last revised on 7/10/2017, indicates that the resident is "dependent on staff for activities, cognitive stimulation, [and] social interaction..." Additionally, it indicates that the resident does not like attending group activities.</p> <p>Further review of the care plan revealed interventions, initiated on 1/12/2016, to "provide 1 to 1 bedside/in-room visits and activities" and "enjoys 1:1 conversation with activities staff."</p> <p>Record review of the activity documentation in the electronic medical record on 7/28/2021 revealed that the resident participated in a one to one activity on 7/27/2021. Further record review revealed that this was the only documented activity with the resident in the past 30 days.</p> <p>During an interview with the resident's family member on 7/27/2021 at 9:33 AM, he raised concerns relative to the lack of social interaction</p>	F 679			

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F 679	Continued From page 18 the resident was receiving at the facility. During a surveyor interview with the Activities Director on 7/28/2021 at 9:23 AM, he indicated that he would expect one on one activities to be done with this resident a minimum of three times per week. Additionally, he revealed that all activities, including one on one activities, would be documented in the electronic medical record. During a surveyor interview with the activity aide, Staff H, on 7/28/2021 at 12:36 PM, she could not indicate how often the resident is involved with a one on one activity. Additionally, she indicated that if she was to sit down with the resident for an activity, it would be documented in the electronic medical record. During an additional interview with the Activities Director on 7/29/2021 at 11:45 AM, he acknowledged that there was only one activity documented in the resident's electronic medical record in the past 30 days. Additionally, he could not provide evidence that activities were provided in accordance with the resident's plan of care.	F 679			
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	F 695 <i>WR</i> <i>8/11/21</i>	As a POC for Tag F695: a) Resident ID#13 did not have any negative outcome; the oxygen was being delivered as ordered. b) We have since reviewed all residents with orders for Oxygen to ensure transcription to TAR was completed and signing off is being done. c) The nurses have been (re) educated regarding the expected follow through associated with Oxygen orders and signing off Oxygen when applied. We		

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F 695	<p>Continued From page 19</p> <p>by: Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to provide respiratory care consistent with professional standards of practice for 1 of 2 sample residents reviewed for oxygen therapy, Resident ID #13.</p> <p>According to Brunner and Sudarth's textbook, Medical and Surgical Nursing, 7th Edition, 1992, p.524, "as with other medications, oxygen is administered with care, and its effects on each patient are carefully assessed. Oxygen is a drug and except in emergency situations is prescribed by a physician."</p> <p>Findings are as follows:</p> <p>Record review revealed the resident was admitted to the facility in April of 2021, with diagnoses including, but not limited to, atrial fibrillation (a rapid, irregular heart rhythm), aortic valve stenosis (narrowing of the valve in the vessel of the heart), and asthma (an inflammatory disease of the airways of the lungs).</p> <p>Record review of the resident's admission Minimum Data Set (MDS) assessment, dated 4/23/2021, under Section O-Special treatments, procedures, and programs, revealed s/he was coded as receiving oxygen within the last 14 days, during the assessment period.</p> <p>During surveyor observations on 7/27/2021 at 1:15 PM, 7/28/2021 at 9:38 AM and 7/29/2021 at 9:00 AM, the resident was observed receiving oxygen therapy via nasal cannula at 2 liters.</p> <p>Further record review revealed a physician's</p>	F 695	<p>are not anticipating any further issues in this regard. The nursing management team will monitor this</p> <p>d) The DNS/designee in responsible for implementation of this plan. An audit has been devised to ensure compliance. The plan and audits will be reviewed by the QAPI committee no less than monthly for the next 3 months after which time, the Committee will determine the need to continue the formal audits based on our level of compliance. If necessary, the plan will be revised as needed to ensure compliance.</p>		

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F 695	Continued From page 20 order dated 4/21/2021 for oxygen at 2-3 liters per minute via nasal cannula as needed for shortness of breath. Record review of the July 2021 Treatment Administration Record (TAR) failed to reveal the oxygen order was signed off as administered. Additionally, the TAR failed to reveal a physician's order for continuous oxygen therapy. During a surveyor interview on 7/28/2021 at 2:16 PM with the unit nurse Staff I, she confirmed that the resident receives continuous oxygen.	F 695			
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records,	F 842 <i>WR</i> <i>8/19/21</i>			

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F 842	<p>Continued From page 21</p> <p>regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed</p>	F 842	<p>As a POC for Tag 842:</p> <p>a) Residents ID#13, #55 and #391 did not experience any negative outcome associated with the documentation issues identified by the surveyors.</p> <p>b) We have since reviewed those with orders for Oxygen to ensure proper signage is being done for use of Oxygen and changing of tubings. We have also since reviewed TARs to ensure items ordered are being signed off accordingly.</p> <p>c) The nursing staff have been (re) educated on the importance and regulatory requirements of proper and timely documentation of care and services ordered by the MD.</p> <p>d) The nursing management team will conduct routine audits to ensure proper signing and documentation is being done routinely. Audit findings will be shared with the QAPI Committee on a routine basis. We will monitor this improved system for no less than 3 months to ensure effectiveness of the plan. The QAPI Committee will determine the need to continue with the formal audits based on our level of success and compliance.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2021
NAME OF PROVIDER OR SUPPLIER WEST VIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 239 LEGRIS AVENUE WEST WARWICK, RI 02893		
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F 842	<p>Continued From page 22</p> <p>professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. 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 maintain medical records for each resident that are complete and accurately documented, in accordance with accepted professional standards of practice, for 3 of 19 residents, Resident ID #'s 13, 55, and 391.</p> <p>Findings are as follows:</p> <p>1. Record review for resident ID #13 revealed the resident was admitted to the facility in April of 2021 with diagnoses including, but not limited to, atrial fibrillation (a rapid, irregular heart rhythm), aortic valve stenosis (narrowing of the valve in the vessel of the heart), and asthma (an inflammatory disease of the airways of the lungs).</p> <p>Record review revealed a physician's order dated 4/12/2021 for oxygen at 2-3 liters per minute via nasal cannula as needed for shortness of breath.</p> <p>During surveyor observations on 7/27/2021 at 1:15 PM, 7/28/2021 at 9:38 AM and 7/29/2021 at 9:00 AM, the resident was observed receiving oxygen therapy via nasal cannula at 2 liters.</p> <p>Record review of the resident's July 2021 Treatment Administration Record (TAR) failed to reveal evidence that the oxygen was signed off as administered.</p> <p>During a surveyor interview on 7/28/2021 at 2:16 PM with Staff Nurse I, she indicated that the</p>	F 842			

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F 842	<p>Continued From page 23 resident receives oxygen continuously.</p> <p>2. Record review for Resident ID #55 revealed the resident was admitted to the facility in September of 2020 with diagnoses that include, but are not limited to, dysphagia (difficulty swallowing) and pneumonia.</p> <p>During an interview with the resident on 7/26/2021 at 9:19 AM, s/he revealed his/her dentures had fallen out of his/her mouth in December 2020 and were broken. Surveyor observation at the time of the interview revealed the resident did not have dentures.</p> <p>During an interview on 7/28/2021 at 12:21 PM with nursing assistant, Staff F, during lunch, she stated, "yes [the resident] does have dentures, they were too big...they were being repaired unless [s/he] hasn't gotten them back." Staff F checked the residents bedside table and could not find any dentures. She then asked the resident and s/he stated they were sent out and can't be fixed.</p> <p>During an interview with the social worker, Staff G, on 7/29/2021 at 10:04 AM, he provided documentation that the resident's dentures had been sent out for repair in February 2021, but the dentist was unable to repair them.</p> <p>Record review of the point of care documentation for July of 2021 revealed the staff were signing that the resident's dentures were in place for 52 of 60 opportunities. When brought to the attention of the Assistant Director of Nursing on 7/29/2021 at 12:45 PM, she was unaware the resident did not have dentures and could not explain why the staff had been signing it off.</p>	F 842			

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F 842	Continued From page 24 3. Record review for Resident ID #391 revealed the resident was admitted to the facility in July of 2021 with diagnoses including, but not limited to, chronic obstructive pulmonary disorder (chronic inflammatory lung disease) and atherosclerotic heart disease of the native coronary artery (narrowing of the arteries). During a surveyor observation on 7/28/2021 at 8:27 AM, the resident was observed receiving oxygen therapy via nasal cannula. The nasal cannula tubing was observed with a date of 6/22/2021. Record review of the resident's TAR revealed a physician's order dated 7/14/2021 to change oxygen cannula every week. The TAR revealed the order was inaccurately signed off as being completed on 7/14/2021 and on 7/21/2021. During a surveyor interview on 7/28/2021 at approximately 2:20 PM with the Assistant Director of Nursing Services, she could not explain why the above noted documentation was inaccurate.	F 842			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880 <i>UR</i> <i>8/19/21</i>	As a POC for Tag F880: <i>Please refer to the DPOC for response. We have completed the Root Cause Analysis (RCA) as instructed as well as the required education. Audits are in process.</i>		

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F 880	<p>Continued From page 25</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p>	F 880			

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F 880	<p>Continued From page 26</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to implement infection control measures to prevent the potential transmission of COVID-19 relative to properly utilizing Personal Protective Equipment (PPE).</p> <p>Findings are as follows:</p> <p>1. During a surveyor observation on 7/26/2021 at 1:43 PM, nurse, Staff J, was wearing an N95 mask incorrectly. The bottom strap of the N95 was not positioned around her neck and below her ears, instead it was positioned under her chin. During a surveyor interview at the time of the observation, Staff J acknowledged that the bottom strap was not positioned correctly.</p> <p>During an interview with the Assistance Director of Nursing Services (ADNS) on 7/26/2021 at 1:48 PM, she acknowledged that Staff J was wearing the N95 mask incorrectly.</p>	F 880	<p>You are hereby directed by the Rhode Island Department of Health, Center for Health Facilities Regulation to immediately implement the following Directed Plan of Correction.</p> <ol style="list-style-type: none"> 1. A QAPI regarding the proper use of personal protective equipment (PPE) shall be completed by 8/11/2021. 2. A QAPI regarding COVID-19 visitation shall be completed by 8/11/2021. 3. Conduct an updated Root Cause Analysis which will be completed with assistance from the Infection Control Preventionist or QAPI committee by 8/11/2021. 4. All staff will attend an in-service conducted by the Infection Control Preventionist/Designee or an outside 		

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F 880	<p>Continued From page 27</p> <p>2. Record review for Resident ID #292 revealed s/he was admitted to the facility in July of 2021 and was placed in a quarantine room. The resident's room was designed with a sign at the door, which indicated "Stop Quarantine...Full PPE beyond this point...face shield, gown, gloves, N95 with surgical mask on top...Don [put on] prior to entering room, Dof [remove] upon exiting room..."</p> <p>During a surveyor observation on 7/27/2021 at 12:10 PM and 7/29/2021 at 12:11 PM, a visitor was at the bedside wearing only an N95, gown, and gloves. The visitor was observed not wearing eye protection (face shield or goggles) on both days.</p> <p>3. Record review for Resident ID #291 revealed s/he was admitted to the facility in July of 2021 and was placed in a quarantine room. The resident's room was designed with a sign at door, which indicates "Stop Quarantine...Full PPE beyond this point...face shield, gown, gloves, N95 with surgical mask on top...Don prior to entering room, Dof upon exiting room..."</p> <p>During a surveyor observation on 7/27/2021 at 12:13 PM a nursing assistant, Staff K, entered the resident's room wearing only an N95, gown and gloves. Staff K was observed not wearing a surgical mask over the N95 as well as not wearing any eye protection (face shield or goggles).</p> <p>During an interview with Staff K on 7/27/2021 at 12:15 PM, she revealed she is supposed to wear the face shield upon entering the quarantine room. Staff K also revealed she is supposed to wear a surgical mask over the N95 mask and</p>	F 880	<p>qualified individual on infection control practices. This in-service will focus on the proper use of PPE and visitation. An attendance sheet will be completed, and this in-service will be completed by 8/11/2021.</p> <p>5. The facility shall set up a system to ensure all visitors are aware of infection control guidance. This shall be completed by 8/11/2021.</p> <p>6. Starting 8/11/2021, the Infection Control Preventionist/Designee will conduct observations of infection control practices at least twice a week during each of the following time periods: 7:00 AM to 3:00 PM; 3:00 PM to 11:00 PM; and 11:00 PM to 7:00 AM. These six (6) observations each week will be documented and will include the following: the date and time of the observation; the name of the staff being observed; what activity was observed; the result of the observations; any corrective action needed; and any re-education of staff.</p> <p>7. At least 50% of the observations will focus on the issue(s) identified in the deficient practice(s) cited.</p> <p>8. The same staff will not be observed again until all staff have been observed unless an issue was identified with a staff member's infection control practice.</p> <p>9. At least monthly, the Infection Control Preventionist/Designee will submit a report of his/her observations and needed</p>		

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8/11/21

