STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415041	A. BUILDING ______ B. WING ______	01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOONSOCKET HEALTH CENTRE	262 POPLAR STREET WOONSOCKET, RI 02895

(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 and Complaints Investigation Survey, ACTS Reference Number 83240, was conducted at Woonsocket Health Centre from 1/24/2022 through 1/27/2022 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. A State licensure and emergency preparedness surveys were also conducted at this facility. Deficiencies were cited.	F 000	RECEIVED FEB 16 2022 FACILITIES REGULATION	2/26/22
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 that services provided meet professional standards of quality regarding following physician orders relative to hepatic drain treatments, Resident ID #266. Findings are as follows: According to Mosby's, Fundamentals of Nursing Concepts, Process and Practice, 4th Edition on page 809 "the registered nurse checks all transcribed orders against the original order for accuracy and thoroughness." Review of the facility policy titled, "Admissions Policy and Procedure", revealed in part, "...Verify	F 658 lla 2/17/22	For ID # 266, an order was obtained to flush the hepatic drain with 10 ml normal saline daily. COC's have been reviewed on all new admissions to ensure that all discharge instructions have been added to orders. Education will be provided to nurses to ensure that two nurses are reviewing/verifying COC discharge paperwork, and all orders are entered are appropriate. Admission audits will be conducted in a timely manner to ensure all orders have been transcribed appropriately. Results of audits will be reported to the QAPI Committee.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature], NHA
TITLE: Administrator
(X6) DATE: 2/16/22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 658	Continued From page 1 the orders from the COC [Continuity of Care] with the physician..." Review of the record revealed s/he was admitted to the facility in January of 2022 with diagnoses including but not limited to malignant neoplasm of colon (cancerous tumor of the large intestine) and secondary malignant neoplasm of liver (cancer that started in another part of the body and has now spread to the liver) and intrahepatic bile duct (small tubes that carry bile). Review of the hospital discharge COC documentation revealed in part, "...You will be discharged with a drain to your abdomen. This drain needs to be flushed once a day with 10 mL (milliliters) of normal saline in a syringe..." Review of the current physician orders for January 2022 failed to reveal evidence of an order to flush the hepatic drain. During an interview with Staff Nurse A on 1/26/2022 at 11:50 AM, he acknowledged the resident does not have a current order to flush the drain.	F 658 Ra 2/17/22		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		

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F 684	Continued From page 2 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 each resident receives treatment and care in accordance with professional standards of practice for 1 of 5 sample resident's relative to weight change and respiratory status, Resident ID #51. Findings are as follows: The facility's "PROTOCOL FOR ADDRESSING WEIGHT CHANGES" state in part; "... "If the weight change is extreme and appeared inaccurate. Notify the charge nurse and reweigh perhaps on a different scale ... If there is a #5 weight change let the charge nurse know... Once notified the charge nurse should -Notify the dietitian and document in the chart. -Address in the resident care plan. If applicable the Charge nurse may also; Notify physician... If #5 [pounds] or greater weight gain has occurred, check for possible reasons such as edema [swelling, puffiness], ascites [fluids builds up in abdomen]...Follow up with appropriate disciplines as needed." Record review for this resident revealed s/he was originally admitted to the facility in November 2020. The resident has diagnoses to include but are not limited to; pulmonary embolism (blood clot in the lungs), hypertension (high blood pressure), ischemic cardiomyopathy (weakened heart muscle), atrial fibrillation (irregular and often very rapid heart rhythm), generalized edema (swelling, puffiness), chronic obstructive pulmonary disease	F 684	The weight gain for resident ID # 51 was reported to the NP. [redacted] weight is now monitored weekly and reported to the NP/MD, dietician and family member for any weight changes +/- 5 pounds. [redacted] is monitored for edema. An order was obtained for 2 liters of O2 as needed to maintain pulse ox greater than 90. The care plan was updated to reflect changes. All weights, O2 orders and associated care plans have been reviewed for residents utilizing O2, and for those who have weight changes, and care plans updated. Nurses will be educated on reporting weight changes +/- 5 lbs to MD/NP, dietician and family and documentation of same. Education will be provided ensuring O2 orders are obtained and added when O2 is being utilized in non-emergency situations, updating care plans for changes in weight and oxygen orders. The DNS or [redacted] designee will conduct weekly audits of weights to ensure	2/17/22

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F 684	Continued From page 3	F 684		

(chronic inflammatory lung disease), pleural effusion (excessive collection of the fluid around the lungs) and chronic kidney disease.

Additional record review revealed the following progress notes:

-1/5/2022 at 5:30 PM "...wgt [weight] today 187.6 lbs [pounds], [15.2 lbs weight gain from 12/10/2021 (172.4 lbs), 8.82 % in less than a month]...

-1/6/2022 at 4:23 PM, "...Today weight is 189 lbs [weight gain 1.4 lbs from 1/5/2022, and 16.6 lbs from 12/10/2021, 9.63 % in less than a month], reported to [dietitian] who order to repeat it tomorrow and if accurate to check TSH (thyroid stimulating hormone) level..."

-1/11/2022 at 6:01 PM, "...Wgt today 187 lbs (14.6 lbs weight gain from 12/10/2022, 8.47 % in a month).

Further record review failed to reveal evidence that the dietitian was notified of the reweigh on 1/11/2022. Additionally, there is no evidence that the physician or nurse practitioner were notified of the weight gain.

Record review failed to reveal evidence that the care plan was updated to address the weight change or that the resident was monitored for edema and/or ascites.

Additional record review revealed the following progress notes regarding his/her respiratory status/oxygen use:

-1/7/2022 at 4:16 PM, "...on o2 [oxygen] at 2

Provider's Plan of Correction (F 684):

all weight changes have been reported appropriately. Random audits of O2 orders and care planning for same will be conducted. Results will be reported to the QAPI Committee

UR 2/17/22

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F 684	Continued From page 4	F 684		

liters,...denies SOB [shortness of breath] at this time, ls [lung sounds]: clear..."

-1/8/2022 at 12:07 AM, "...on 2L [liters] Oxygen..."

-1/10/2022 at 11:30 PM, "...at 2L continuous Oxygen..."

-1/11/2022 at 6:01 PM, "... O2 2L...[oxygen 2 liters]..."

-1/12/2022 at 4:22 PM, "...on 2 L [liters]..."

-1/13/2022 at 12:55 AM, "...at 2 L Oxygen..."

Further record review failed to reveal evidence of a physician's order for oxygen. Additionally, review of the care plan failed to reveal evidence of a plan of care relative to oxygen therapy.

Further record review revealed that this resident went to his/her cardiology clinic on 1/13/2022 at 1:00 PM.

Review of a progress note dated 1/13/2022 at 4:06 PM revealed the resident was sent to the hospital from the cardiology clinic and the resident was admitted to the hospital with a diagnosis of congestive heart failure (CHF) and abdominal distention.

Review of the hospital discharge summary dated 1/19/2022 revealed:

"...Discharge Diagnosis: Acute on chronic systolic CHF exacerbation...

Cardiology:

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F 684	Continued From page 5	F 684		

Continued From page 5

Patient presented with progressive edema and dyspnea on exertion [shortness of breath/air hunger/difficulty with breathing] ...BNP (brain natriuretic peptide; small amounts are found in the blood stream) greater than 17,000 [normal level less than 125 pg/ml (picograms per milliliter), if levels were higher than normal, it usually means is indicative heart failure]...on a lasix drip [medication that reduces fluid in body] with optimal respond...and leg edema has improved...

Renal:

It appears patient has had worsening creatinine in the setting of CHF exacerbation...likely cardiorenal syndrome [abnormal heart function that is associated with abnormal kidney function]..."

During an interview with the Director of Nursing Services (DNS) on 1/26/2022 at 9:02 AM, she revealed that if a resident has a weight gain of 3 lbs or more that the dietitian and physician should be notified. The DNS stated, although the policy and procedure for addressing the weight change indicates 5 lbs weight change for a notification, she stated that the dietitian "likes it this way". The DNS stated that if staff notify the dietician or the physician, they should document in the record. The DNS further stated she is aware of the 15.2 lbs weight gain and that staff should have reweighed the resident next day. She was unable to provide evidence that the resident's physician and/or nurse practitioner were notified relative to the resident's weight gain. The DNS was also unable to provide evidence that a care plan had been updated to address the weight change or that the resident was monitored for edema or

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F 684	Continued From page 6 ascites after 1/5/2022. During an interview on 1/27/2022 at 9:50 AM, with the dietitian she revealed she was notified on 1/6/2022 relative to the 15.2 lbs weight gain. She revealed her recommendations, were to recheck the weight and notify the physician to obtain an order to check TSH level. She indicated a reweigh should be obtained within 24-48 hours. She revealed she was not notified relative to the reweigh on 1/11/2022. During an interview with the Nurse Practioner, Staff E on 1/27/2022 at 10:04 AM, she revealed she was not aware of the weight gain. Staff E stated "No one told me....I would go in and see [him/her] right away. I'm there almost every day." Staff E further revealed the resident goes to the cardiologist and they manage his/her medications and staff should notify the cardiologist as well. Additionally, Staff E revealed that the resident is very compromised and if staff had told her that the resident gained 15 pounds, she would have seen the resident and prescribed Lasix (a medication that reduces fluid in body). Staff E further revealed she was not aware that the resident received oxygen on 1/7, 1/8, 1/10, 1/12 and 1/13/2022. Staff E stated "that would have prompted me to see (him/her) right away...(S/he) was going into CHF (congestive heart failure)..." During a phone interview with the resident's cardiologist on 1/27/2022 at 10:37 AM, he revealed he saw the resident on 1/13/2022 at approximately 1:30 PM and the resident was "coughing, huffing and could not finish [his/her] sentence...[S/he] was short of breath...and had 3 plus edema [severe swelling]..." The cardiologist further stated when he saw the resident, he knew	F 684		

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F 684	Continued From page 7 that the resident needed to go to the hospital "right away." The cardiologist further revealed the resident was sent from the nursing home and utilizing oxygen during his/her appointment. During an interview on 1/27/2022 at 12:35 PM, the Administrator was unable to provide evidence that the resident received appropriate care and treatment in accordance with professional standards of practice.	F 684		
F 686 SS=D	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 prevent new pressure ulcers from developing for 1 of 9 sample residents reviewed who is at risk for developing pressure ulcers, Resident ID #92.	F 686 [handwritten initials] 2/17/22	Resident ID # 92 has received a new specialized off load pillow. Resident ID # 92 was seen by the Vohra wound MD, who assessed the discoloration to the resident's left heel, and [redacted] confirmed that this is how the stage 4 pressure ulcer healed, and that it is chronic scarring. All residents with orders to off-load heels have ben reviewed. New off-load boots and off-load appliances have been purchased for less mobile/ high risk residents. In servicing will be conducted on proper techniques and equipment to be utilized to off load heels. Random audits will be conducted on residents utilizing off-load devices to	

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F 686	Continued From page 8 Findings are as follows: Record review revealed the resident was admitted to the facility in June of 2021 with diagnoses which include, but are not limited to, dementia, abnormalities of gait and mobility. Record review of a Norton Plus Pressure Ulcer Scale (an assessment used to predict the risk for developing pressure ulcer) dated 1/8/2022 states in part, "...Stg [stage] 4 ulcer to left heel resolved. Preventive skin care as ordered..." Additionally, this assessment revealed the resident scored a 7 which indicates s/he is at a high risk for developing a pressure ulcer. Record review of a care plan dated 10/4/2021 which states in part "...alteration in skin integrity D/T [due to] high risk for skin breakdown, extensive assist with bed mobility...HX [history] of Stage 4 pressure ulcer to the left heel.... interventions include: monitor for s/s [signs/symptoms] of skin breakdown-consult MD [medical doctor] promptly for intervention...RX.'s, A/O [treatments as order]..." Record review of a current physician's order dated 6/4/2021 states in part "Off load heels when in bed every shift..." During a surveyor observation on the following dates and times the resident was observed lying in bed with his/her heels resting directly on the bed and the pillow and not off loaded as ordered: - 1/25/2022 at 8:54 AM - 1/26/2022 at 9:46 AM and 10:38 AM	F 686 MC 4/17/22	ensure heels are properly off-loaded. Results will be reported to the QAPI Committee.	

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F 686	Continued From page 9 During a surveyor observation on 1/26/2022 at approximately 10:39 AM in the presence of Staff F, revealed the resident lying in bed and both of his/her heels were resting directly on a pillow and not off loaded as ordered. Further observation revealed a dark discolored area approximately 2 centimeters on his/her left heel. During a surveyor interview immediately following this observation with Staff F, she acknowledged the resident's heels were not offloaded as ordered. She further acknowledged the dark discolored area on the resident's left heel and could not provide evidence as to when the resident had developed this area. During a surveyor interview on 1/27/2022 at 1:52 PM with the Administrator, she indicated that she would expect the resident heels to be off loaded as ordered. She further indicated that she would expect the staff to document any changes in the resident skin and report changes to the physician when observed.	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition	F 692 KR 4/7/22	Residents ID # 57 and 96 had their weight changes reported to the MD/NP, dietician and family, and care plans were updated to reflect loss/gain. Both residents will continue to be on weekly weights. Weights have been reviewed on all residents and reported as necessary. Education will be provided to the nursing staff on the weight policy, to	

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F 692	Continued From page 10 demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight for 2 of 3 sample residents reviewed, Resident ID#'s 57 and 96. Findings are as follows: Record review of a policy titled, "Protocol for Addressing Weight Changes" states in part: "If there is a 5# [pound] weight change...notify the dietitian. Address in the resident care plan..." Additionally, the protocol stated in part., "...if applicable. Notify physician. Place on weekly weights. If 5# or greater weight gain check for possible reasons...follow up with appropriate disciplines as needed." 1. Record review for Resident ID #96 revealed that s/he was admitted to the facility in December of 2021 with diagnoses including but not limited to Alzheimer's disease with early onset and essential primary hypertension (high blood pressure). Review of the weight documentation revealed the following:	F 692	ensure weight changes are reported accordingly on all residents, and care plans are updated as necessary. The dietician has been educated on WH&RC's weight policy. Weights will be reviewed by the DNS or her designee weekly to ensure weight changes are addressed appropriately. Results will be reported to the QAPI Committee.	

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F 692	Continued From page 11	F 692		

Continued From page 11

-12/28/2021: 264 lbs.
-12/30/2021: 271 lbs.
-1/4/2022: 282 lbs.
-1/5/2022: 282 lbs.
-1/20/2022: 297 lbs.
-1/21/2022: 292 lbs. (pounds)

Record review revealed a 1/10/2022 care plan, which stated in part, "...Alteration in nutrition/potential for fluid volume deficit...D/T [due to] high BMI [body mass index]...HTN [hypertension]..." The care plan failed to reveal reasons for weight gain or approaches to manage the weight gain.

Additional record review failed to reveal evidence that other disciplines were notified of the 6.82 %, or 18 lbs. weight gain, from 12/28/2021 to 1/5/2022.

During a surveyor interview on 1/27/2022 at 11:20 AM with the dietitian regarding the protocol for notification of weight changes of 5 lbs. or greater, she revealed that she had not seen the policy.

2. Record review of Resident ID# 57 revealed s/he had a diagnosis that included but was not limited to Alzheimer's Disease.

Record review of his/her weight documentation revealed the following:

- 12/27/2021 151 lbs.
- 1/1/2022 152.4 lbs.
- 1/3/2022 150 lbs.
- 1/20/2022 142 lbs.
- 1/24/2022 142 lbs.

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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
F 692	Continued From page 12 Further record review failed to reveal evidence that the dietitian or physician were notified of the weight loss of 5% in 21 days (1/3/2022 to 1/24/2022). Additional record review revealed a nursing note dated 1/26/2022 indicating a weight loss of 6 lbs. from 1/3/2022 to 1/26/2022 and to continue weekly weights. Additional record review failed to reveal evidence of the resident's weight for the week of 1/10/2022. Further record review revealed the plan of care was not updated to reflect resident's weight change. During a surveyor interview with dietitian on 1/27/2022 at approximately 11:20 AM, she could not provide evidence that a second reweight was done. During a surveyor interview with the Administrator on 1/27/2022 at approximately 1:30 PM, it was revealed that her expectation is that the dietitian would be made aware of any weight change within 24 to 48 hours. Additionally, the expectation would be that the dietitian should be aware of the facility's nutrition policy.	F 692		
F 695 SS=E	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	F 695 HR 2/17/22	For resident's ID # 51, 71, 84 and 106, orders were obtained for oxygen with specific liter flows, and care plans were updated to reflect use. All residents requiring O2 have had	

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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 a resident who needs respiratory care is provided such care, consistent with professional standards of practice, for 4 of 6 residents reviewed for oxygen therapy, Resident ID #'s 51, 71, 84 and 106.

Findings are as follows:

According to Brunner and Sudarth's textbook, Medical and Surgical Nursing, 7th Edition, 1992, p. 524, "as with other medications, oxygen is administered with care, and its effects on each patient are carefully assessed. Oxygen is a drug and except in emergency situations is prescribed by a physician."

1. Record review for Resident ID #51 revealed s/he was originally admitted to the facility in November of 2020 with diagnoses including but not limited to pulmonary embolism (blood clot in the lungs), ischemic cardiomyopathy (weakened heart muscle), chronic obstructive pulmonary disease (chronic inflammatory lung disease), and pleural effusion (excessive collection of this fluid around the lungs).

Additional record review revealed the following nurse progress notes:

-1/7/2022 at 4:16 PM, "...on o2 [oxygen] at 2 liters,...denies SOB [shortness of breath] at this time, ls [lung sounds]: clear..."

Provider's Plan of Correction (F 695):

their orders reviewed to ensure O2 orders are in place with specific liter flows, and the care plans updated as necessary.

Education will be provided to nurses to ensure O2 orders are obtained and in place for all residents utilizing O2, with specific liter flows, and O2 usage is reflected in the care plan.

Random audits will be conducted on O2 orders and associated care plans to ensure orders with specific liter flows are in place and are reflected on the care plan. Results will be reported to the QAPI Committee.

Completion date (handwritten): MR 2/17/22

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F 695	Continued From page 14 -1/8/2022 at 12:07 AM, "...on 2L [liters] Oxygen..." -1/10/2022 at 11:30 PM, "...at 2L continuous Oxygen..." -1/11/2022 at 6:01 PM, "... O2 2L...[oxygen 2 liters]..." -1/12/2022 at 4:22 PM, "...on 2 L. [liters]..." -1/13/2022 at 12:55 AM, "...at 2 L Oxygen..." Further record review failed to reveal evidence of a physician's order for Resident ID #51 to receive oxygen. Additionally, review of the care plan failed to reveal evidence of a plan of care relative to oxygen therapy. During an interview with the Director of Nursing Services on 1/26/2022 at 10:30 AM, she was unable to provide evidence of a physician's order for the resident to receive oxygen and a care plan for oxygen therapy. During an interview with the Nurse Practitioner, Staff E on 1/27/2022 at 10:04 AM, she revealed that she was unaware that the resident had received oxygen on the above dates and times. Furthermore, she revealed that she did not order oxygen to be administered to this resident. During an interview with the unit nurse, Staff D on 1/27/2022 at 10:25 AM, she revealed the resident received oxygen therapy on the first shift on 1/12/2022 and 1/13/2022. However, she was unable to provide evidence of an order for oxygen or explain why the resident was receiving the oxygen therapy.	F 695		

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2. Record review revealed Resident ID #71 was admitted to the facility in July of 2021 with diagnoses to include, but not limited to dementia, anemia and acute kidney failure.

Record review revealed a physician order dated 1/10/2022 which states "PRN [as needed] oxygen if O2 saturation drop below 89%..."

Record review failed to reveal evidence of a flow rate of oxygen to be administered to the resident.

Additionally, record review failed to reveal evidence that a care plan was developed relative to the resident's respiratory care and oxygen therapy.

3. Record review revealed Resident ID #84 was admitted to the facility in September of 2014 with diagnosis which include, but not limited to, acute respiratory disease.

Record review revealed a physician's order dated 9/2/2020 which states in part, "O2 [oxygen] humidified via nasal cannula [a tube use to deliver oxygen] to maintain POX [pulse oximeter, a test used to measure the oxygen level] above 90% every shift..."

Record review of the physician's order failed to reveal evidence of a flow rate of oxygen to be administered to the resident.

Record review of a quarterly Minimum Data Set (MDS) assessment dated 12/19/2021 revealed Resident ID #84 is receiving oxygen therapy.

Record review failed to reveal evidence that a

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F 695	Continued From page 16 care plan was developed relative to the resident respiratory care and oxygen that is being administered. During surveyor observations made on 1/24/2022 at 10:16 AM, 1/25/2022 at 11:00 AM, 1/26/2022 at 9:25 AM, and on 1/27/2022 at 11:06 AM revealed the resident was receiving oxygen via nasal cannula at 2 liters per minute. Record review of progress notes from December 2021 through January 27, 2022, revealed staff documentation indicating the resident is receiving both 2 and 3 liters of oxygen. During a surveyor interview on 1/27/2022 at 11:17 AM with Staff F, she acknowledged that the physician's order for oxygen did not indicate a flow rate. During a surveyor interview on 1/27/2022 at 11:25 AM, with Staff G, she acknowledged that the resident is receiving oxygen. She further acknowledged that a care plan was not initiated relative to oxygen being used. During a surveyor interview on 1/27/2022 at 1:30 PM and on 1/27/2022 at 1:49 PM with the Administrator, she revealed that she would expect the staff to include a flow rate in the order to indicate the liters of oxygen to be administered to the resident. She further indicated that she would expect a care plan to be initiated reflecting that oxygen is being administered. 4. Review of the record for Resident ID #106 revealed that s/he was admitted to the facility in January of 2022 with diagnoses including but not limited to ventilator associated pneumonia,	F 695		

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F 695	Continued From page 17 chronic respiratory failure, and obstructive sleep apnea. Review of a January 2022 document titled, "Physician Order Report", revealed a 1/7/2022 order that states in part, "...titrate FiO2 [fraction of inspired oxygen] to keep SpO2 [oxygen saturation] > [greater than] 92% every shift..." Review of the January 2022 progress notes failed to reveal evidence of an oxygen liter flow rate on the following dates: - 1/12/2022 at 10:47 PM - 1/16/2022 at 11:59 PM - 1/19/2022 at 11:01 PM - 1/20/2022 at 5:16 PM - 1/21/2022 at 6:25 AM - 1/23/2022 at 12:06 AM, 5:23 PM and 10:23 PM - 1/25/2022 at 10:07 PM - 1/26/2022 at 8:45 PM and 10:42 PM During an interview with Nurse, Staff C on 1/27/2022 at 11:45 AM, she acknowledged that the oxygen order did not include a liter flow. During an interview with the Nurse Practitioner, Staff E on 1/28/2022 at 1:50 PM, she indicated her expectation is that the oxygen order would include a liter flow.	F 695		

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F 759	Continued From page 18	F 759		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that each resident's medication regimen is free of medication error rates of 5% or greater. Based on 31 opportunities for error, there were 3 errors involving one resident, Resident ID #2, resulting in an error rate of 9.68%. Findings are as follows: Review of the facility policy dated 9/2009 titled "Medication Administration Safety Program" states in part "...Medications are crushed only on the order of a physician and in accordance with pharmacy guidelines..." Record review revealed this resident has the following physician's orders: 1. "Protonix (a medication use to treat high levels of stomach acid) tablet, delayed release (DR/EC) [delayed release/enteric coated]; 40 mg [milligram] once a day, start date: 10/31/2020..." Instructions on the pharmacy label states in part, "...Swallow whole, Do not chew/crush..." 2. "Toprol XL (metoprolol succinate, a medication use to decrease blood pressure and lower heart	F 759	For resident ID #2, the CMT was educated to give non-crushable meds whole in applesauce, and to notify the nurse if resident unable to take meds whole in applesauce, so that MD/NP can be made aware and change medication orders if needed. All residents receiving crushed meds have been reviewed and orders changed as necessary. Education will be provided to nurses and CMT's to ensure that meds deemed unable to be crushed, should not be crushed for any reason. Education will also include the need for CMT's to report to nurses any resident who is unable to take uncrushable meds whole in applesauce, so that the MD/NP can be notified, and make changes as necessary. Audits will be conducted on all residents with orders to crush meds to ensure meds ordered are able to be crushed. Results will be reported to the QAPI Committee.	[handwritten: initials 2/17/22]

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F 759	Continued From page 19 rate) tablet extended release 24 hr [hour]: 25 mg: amount to administer: 1 tab. start date 3/5/2021..." Instructions on the pharmacy label states in part, "...Not to be chewed or crush..." 3. "Toprol XL (metoprolol succinate) tablet extended release 24 hr [hour] 25 mg: amount to administer: 1/2 tab (12.5 MG) start date 3/5/2021..." Instructions on the pharmacy label states in part, "...Not to be chewed or crush..." During a surveyor observation of the medication administration task on 1/26/2022 at 8:30 AM with a Certified Medication Technician, Staff H, she was observed crushing the above-mentioned medications, put them in apple sauce and indicated she was ready to administer the medications. Staff H proceeded to administer the medications after it was brought to the attention of the staff by the surveyor that the above-mentioned medications should not be crushed. During a surveyor interview on 1/26/2022 at 8:48 AM with the nurse, Staff C, she acknowledged that the medications should not have been crushed and administered to the resident. During an interview immediately following this observation with Staff F, she acknowledged that the above-mentioned medications were crushed and administered to the resident. She stated, "I always crush the medications." During a surveyor interview on 1/26/2022 at 9:52 AM with the licensed pharmacist, Staff I, he indicated that the medications should not be crushed as indicated on the pharmacy label.	F 759		

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F 759	Continued From page 20 During a surveyor interview on 1/26/2022 at 12:03 PM with the Director of Nursing Services, she indicated that she would expect the medications not to be crushed as indicated on the pharmacy label.	F 759		
F 761 SS=F	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. §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 and staff interview, it has been determined that the facility failed to store and label drugs and biologicals in	F 761 MR 2/17/22	All medication carts were cleaned for pill debris in the bottom of the carts. Expired meds were discarded, and eye drops were dated. All medication carts and medication refrigerators were inspected for proper storage of meds. Medication carts and medication refrigerators will be cleaned on a weekly basis. Education will be provided to nurses and CMT's regarding appropriate med storage protocol, including discarding expired meds, proper dating of appropriate meds, and weekly cleaning of medication carts and medication refrigerators. Random audits of medication carts will be conducted to ensure compliance. Results will be reported to the QAPI Committee.	

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F 761	Continued From page 21 accordance with currently accepted professional principles for 1 of 3 medication storage rooms and 6 of 10 medication carts observed. Findings are as follows: Review of the facility policy dated 9/2009 titled "Medication Administration Safety Program" states in part " ...drugs are stored under proper conditions with regards to sanitation, safety, and expiration date as directed by state and federal regulations and manufacturers guidelines..." 1. Surveyor observation on 1/25/2022 of the Park Square Unit in the presence of Staff J, revealed the following: - Long side medication cart at 2:11 PM revealed 49 loose pills at the bottom of the medication cart - Short side medication cart at 2:25 PM revealed 28 loose pills at the bottom of the medication cart - one bottle of daily multi vitamins with a manufacture expiration date of 12/2021. During a surveyor interview immediately following this observation with Staff J, she acknowledged the that the multi vitamins were expired and she and was unable to identify the loose pills that were in the medication cart. 2. Surveyor observation on 1/25/2022 at 2:23 PM of the Cold Spring Unit medication cart in the presence of Staff K, revealed the following: - Latanoprost 0.005% eye drop (a medication used to lower pressure in the eye), open, in use, and not dated. Manufacture instructions states in	F 761		2/26/22

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part, "...discard 6 weeks after opening..."

- Maxitrol (neomycin-polymyxin b-dexameth) eye drops, suspension; 3.5mg/mL-10,000 unit/mL-0.1 % (a medication used to treat eye infections and inflammation), open, in use, and not dated. Manufacture instructions states in part, "...Write the date on the bottle when you first open the eye drops and throw out any remaining drops after four weeks..."

- Brimonidine tartrate 0.2% eye drop (a medication used to lowering high fluid pressure in the eye and reduces the risk of vision loss), opened, in use, and not dated. Manufacture instructions states in part, "...Discard contents 4 weeks after opening the bottle..."

- Latanoprost 0.005% eye drop, open, in use, and not dated. Manufacture instructions states in part"...discard 6 weeks after opening..."

- Latanoprost 0.005% eye drop, open, in use, and not dated. Manufacture instructions states in part "...discard 6 weeks after opening..."

- 5 loose pills were observed at the bottom of the medication cart

During a surveyor interview immediately following this observation with Staff K in the presence of nurse Staff D, both staff acknowledged the eye drops were open, in use and not dated. Staff K further acknowledged that the loose pills were in the medication cart and was unable to identify the pills.

3. Surveyor observation on 1/25/2022 at 2:48 PM of the Cold Spring Unit medication storage room

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F 761	Continued From page 23 in the presence of Staff D, revealed the following: - Tuberculin Purified Protein Derivative (PPD) solution (is used in a skin test to help diagnose tuberculosis), open and dated 12/22/2021. Manufacture instructions states to discard after 30 days of opening. During a surveyor interview immediately following this observation with Staff D, she acknowledged the PPD solution was expired and should have been discarded. 4. Surveyor observation on 1/25/2022 at 2:55 PM of the Beacon Hill Unit medication cart in the presence of Staff A, revealed: - 4 loose whole pills and multiple broken pieces of pills at the bottom of the medication cart During a surveyor interview immediately following this observation with Staff A, he acknowledged the loose pills were in the medication cart and was unable to identify the pills. 5. Surveyor observation on 1/25/2022 of the Poplar Unit medication cart in the presence of Staff L, revealed the following: - Short Hall medication cart at 3:09 PM revealed 79 loose whole pills and multiple broken pieces of pills were observed at the bottom of the medication cart. During a surveyor interview immediately following this observation with Staff L, she acknowledged the loose pills were in the medication cart and she was unable to identify the pills. She further indicated that the medication cart should have	F 761		2/26/22

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been clean after each shift, and it was not.

6. Surveyor observation on 1/25/2022 of the Poplar Unit medication cart in the presence of Staff M, revealed the following:

- Long side medication cart at 3:11 PM revealed 17 loose pills and multiple pieces of broken pills were observed at the bottom of the medication cart

- Dorzolamide Timolol malate drops; 22.3-6.8 mg/mL; amt: 1 Drop; ophthalmic (a medication used to lower high pressure in the eye) opened and not dated. Manufacture instructions states in part, "...discard 4 weeks after opening..."

During a surveyor interview immediately following this observation with Staff M, she acknowledged the loose pills were in the medication cart and was unable to identify the pills. She further acknowledged that the eye drops were opened and not dated.

During a surveyor interview on 1/26/2022 at 11:29 AM and at 12:03 PM with the Director of Nursing Services, she indicated that she would expect the medication carts to be monitor and cleaned periodically and loose pills should be discarded. She further indicated that would expect the staff to discard expired medications and that eye drops should be dated according to the manufacturer's instructions.

F 880 SS=E Infection Prevention & Control
CFR(s): 483.80(a)(1)(2)(4)(e)(f)

§483.80 Infection Control
The facility must establish and maintain an

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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 2/26/22
F 880	Continued From page 25 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. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F 880 LCS 2/17/22	Staff N was educated on proper use of PPE, proper disinfection of re-usable PPE, and the need for when and how to perform hand hygiene. Staff O was educated on the need to wear eye protection when entering a transmission based precaution room. Staff P was educated on the need to wear an N95 mask per facility policy. The entire area of clean linen storage in the laundry room was reorganized, and linen transferred to linen carts and shelving. All linen is covered. All employees will be educated on proper PPE use, including the need for an N95 mask. Laundry staff was educated on the need to ensure all clean linen must be covered. Random audits monitoring employees for proper PPE use will be conducted by the interdisciplinary team . Random audits of the laundry storage areas will be conducted by the interdisciplinary team to ensure clean linen is covered. A QAPI project was initiated on 2/9/22, to study and evaluate proper PPE usage by employees. The team will conduct audits to ensure compliance and will meet every 2 weeks for the next 6 months to review findings.	

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F 880	Continued From page 26 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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 ensure that healthcare personnel (HCP) utilized Personal Protective Equipment (PPE) according to professional standards to prevent the potential transmission of COVID-19 for 2 of 4 units (Cold Spring and Park Square units). Additionally, the facility failed to store bed linens to prevent the spread of infection in the laundry room. Findings are as follows: Review of the facility's current Policy and	F 880		

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F 880	Continued From page 27 Procedure for "Optimizing PPE During the COVID-19 Response" states in parts, "POLICY: It is the policy of this facility to comply with the CDC and RI Department of Health (DOH) guidelines regarding awareness and prevention of the spread of Corona Virus (COVID-19)... The general strategies CDC recommends to prevent the spread of COVID-19 in LTC [long Term Care] are the same strategies the facility use everyday to detect and prevent the spread of other respiratory viruses like influenza... PROCEDURE:... All employees at WHRC [Woonsocket Health & Rehabilitation Centre] shall wear a N95 mask..." Review of the facility's current Policy and Procedure for Infection Control titled, "COVID-19 Environmental Cleaning" states in part, POLICY: It is the policy of this facility to prevent the spread of COVID-19 within the facility using effective environment cleaning procedures. Infection Control Precautions will be employed by all personnel for all residents. This means that personnel are to wear gloves, gown, facemasks (N-95 if available) and goggles and other personal protective equipment (PPE) whenever exposure to COVID-19 is anticipated. Exposure to COVID-19 can be made through:...contaminated air... PROCEDURE: 1. Adhere to Standard and Transmission-Based Precautions... Hand Hygiene HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and	F 880		

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after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during removal process...

Personal Protective Equipment...Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between use...
Eye Protection
-Put on eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face) upon entry to the patient room or care area...
-Removed eye protection before leaving the patient room or care area.
-Reusable eye protection (e.g.. goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use..."
Gloves...Remove and discard gloves when leaving the patient room or care area, and immediately perform hand hygiene..."

During an interview with the Infection Control Nurse on 1/26/2022 at 1:21 PM, she revealed the rooms with designated droplet precaution signs that staff must wear gowns, gloves, eye protection (face shield or goggles) and an N95 mask upon entering the room. Staff must remove their PPE upon leaving the resident's room and they must wash their hands, wipe the face shield or goggles or throw them away if not able to be cleaned.

1. Surveyor observation of the Cold Spring unit on 1/24/2022 at 10:30 AM revealed a housekeeper, Staff N wearing a gown, gloves, N95 mask and a

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F 880	Continued From page 29 face shield, entering Resident's ID #100's isolation room. The room was designated as a transmission based precaution room with a sign on the door which indicates, "STOP DROPLET PRECAUTIONS EVERYONE MUST; Clean their hands, including before entering and when leaving room. Make sure their eyes, nose and mouth are fully covered before room entry. Remove face protection before room exit." Staff N was observed removing the face shield and gown after mopping the floor. She then discarded the gown into the trash can, removed her gloves and without first performing hand hygiene she swept the floor in front of the resident's room with her face shield hanging by her elbow. Surveyor observation on 1/24/2022 at 10:50 AM, revealed Housekeeping Staff N, cleaning Resident ID #91's isolation room. This room was designated as a transmission based precaution room. Subsequent observations revealed Staff N exiting the room, removing her face shield and then placing it in the housekeeper cart (basket) without cleaning it. Additionally, Staff N was observed removing her gown and gloves and then proceeded to sweep the floor in front of the room without first performing hand hygiene. When the sweeping task was completed, Staff N then walked down the hallway and entered another resident's room. Additional observation on 1/26/2022 at 9:11 AM revealed Staff N mopping the floor while wearing a gown, gloves, an N95 mask and goggles, then entering Resident ID # 55"s isolation room, designated as a transmission based precaution room with a droplet precaution sign outside of the	F 880		

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door. After exiting the room she was observed removing her gown, gloves and goggles then placing the goggles in the basket (housekeeper cart) without cleaning them or performing hand hygiene. After she finished mopping the floor, she then put on a new pair of gloves and proceeded to sweep the floor in the doorway. After the sweeping task was complate, she removed the gloves and was observed putting on a new pair of gloves without performing hand hygiene, then entering another resident's room.

During an interview with Staff N on 1/26/2022 at 9:42 AM, it was revealed that the face shield or goggles are cleaned when she returns to the (housekeeper) closet after cleaning the rooms. It was stated that she does not clean the goggles after exiting each room because there are "so many rooms."

During an interview with the Infection Control Nurse on 1/27/2022 at 12:07 PM, she revealed that both Resident ID #91 and #100 tested positive for COVID-19 on 1/18/2022 and they are both on droplet precautions. The Infection Control Nurse indicated that staff must cleanse the eye protection after removing it or throw it away. Additionally, the Infection Control Nurse revealed that staff must perform hand hygiene after removing their gloves.

2. Surveyor observation of the Park Square unit on 1/24/2022 between 11:08 AM and 11:17 AM revealed that Resident ID #20's room was designated as an isolation room with a droplet precaution sign outside the door. The surveyor observed another housekeeper, Staff O, entering the room then sweeping and mopping the floor without wearing any eye protection.

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F 880	Continued From page 31 During an interview with Staff O on 1/26/2022 at 12:37 PM, it was revealed that he was aware of the correct PPE [personal protective equipment] to wear in a transmission based precaution room however it was stated that he does not wear eye protection all the times because he is not,"...accustomed to it..." During an interview with the Infection Control Nurse on 1/27/2022 at 12:11 PM, it was revealed that Resident ID #20 tested positive for COVID-19 on 1/18/2022 and that s/he is on a droplet precautions. The Infection Control Nurse stated staff must wear eye protection, either a face shield or goggles, when entering a room with a droplet precaution sign. 3. Surveyor observation of the laundry room with the Infection Control Nurse on 1/27/2022 at 12:17 PM, revealed a laundry aide, Staff P, not wearing a mask while folding clean laundry. Interview during the observation with the Infection Control Nurse revealed she acknowledged that Staff P was not wearing a mask and should have been. 4. Additional observation of the laundry room with the Infection Control Nurse on 1/27/2022 at 12:25 PM revealed that there were uncovered piles of clean bed linens (approximately 8 feet long x 4 feet high) placed against the wall. During an interview following the observation with Staff Q, she stated "We have so much. I don't know where to put them and how we can cover them." During the interview with the infection Control Nurse on 1/27/2022 at approximately 12:30 PM, the Infection Control Nurse stated all staff must wear an N95 mask per the facility's policy and	F 880		

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F 880	Continued From page 32 that the linens should be covered.	F 880		