STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 Survey, and complaint investigation survey, ACTS Reference Numbers 94478, 94863, and 94741 was conducted at Trinity Health and Rehabilitation Center from 3/10/2024 through 3/15/2024 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 as a result of this survey.	F 000	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. Completion date for optimal compliance with the POC will be April 14, 2024.	
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the	F 582	RECEIVED APR 04 2024 FACILITIES REGULATION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cheryl Ricard — TITLE: Administrator — (X6) DATE: 4/4/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 582	Continued From page 1 facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to properly provide notice to residents and/or representatives informing when changes in coverage are made to items and services covered by Medicare and/or the state medical plan related to the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) of Non-coverage Form for 2 of 4 residents discharged from Medicare Part A Services that remained in the facility, Resident ID	F 582	**As a Plan of Correction (POC) for Tag F 582:** a) Residents ID#143 no longer lives is the facility. Resident ID#111 and/or their representatives were issued the appropriate notification. b) Residents that reside in the facility who have had a change in coverage, items or services who are covered under Medicare and/or the state medical plan have the potential to be affected by this finding. We have reviewed those residents to identify those affected and made necessary corrections if needed. c) We have reviewed our current system for issuing beneficiary notices and have established appropriate protocols to ensure that the written notices are provided to residents and resident representatives in a timely manner. We have provided education to those staff members involved so that those residents are identified and that the notices are processed accurately and timely. We have devised an audit to monitor our progress with this plan. d) The Administrator (NHA) is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 3 months; at which time, we will determine the need/frequency to continue formal audits.	4/4/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 582	Continued From page 2 #s 111 and 143. Findings are as follows: Review of the Center for Medicare and Medicaid Services (CMS) Form, CMS 100-55, titled "Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage," states in part: "Medicare requires SNFs [Skilled Nursing Facilities] to issue the SNFABN to Original Medicare, also called fee-for-service (FFS) beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is: - not medically reasonable and necessary. - or considered custodial. The SNFABN provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. SNFs must use the SNFABN when applicable for SNF Prospective Payment System services (Medicare Part A)..." 1. Record review revealed that Resident ID #111's last covered day of Medicare Part A Services was on 10/20/2023. Further record review failed to reveal evidence that the resident or resident representative was issued the SNFABN form. 2. Record review revealed that Resident ID #143's last covered day of Medicare Part A Services was on 11/3/2023. Further record review failed to reveal evidence that the resident and/or resident representative was issued the SNFABN	F 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 582	Continued From page 3 form. During a surveyor interview on 3/11/2024 at 10:15 AM with the Minimum Data Set Coordinator, Staff A, she revealed that the above residents should have been issued the SNFABN form and was unable to provide evidence that the SNFABN form was completed. During a surveyor interview on 3/12/2024 at 1:40 PM with the Director of Nursing Services, she was unable to provide evidence that the facility provided the SNFABN notice to the above residents or the resident representatives.	F 582		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 609	Continued From page 4 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to ensure that all alleged violations involving abuse, including injuries of unknown source are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to other officials (Department of Health), in accordance with State law, for 1 of 1 resident reviewed for an injury of unknown origin, Resident ID #129. Findings are as follows: Record review of an undated facility policy titled, "Resident Abuse Prohibition," states in part, "...Any instance...including injuries of unknown origins...must be reported immediately to the DNS [Director of Nursing Services]/designee...The Department of Health and the Alliance for Better Long Term Care will be contacted to report all alleged violations...including injuries of unknown source...immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not	F 609	**As POC for Tag F609:** a) Resident ID#129 does not currently live in the facility. b) Residents who reside in the facility have the potential to be affected by this finding. We have reviewed residents for the presence of injuries for which the cause is unknown and taken appropriate action to report as required. c) We have provided education to the clinical staff regarding the importance of recognizing and identifying injuries of unknown origin by reviewing the regulation and associated reporting requirements. We have reviewed our internal system for complying with required reporting to ensure that reports of injuries of unknown origin are accurate and timely. We have devised an audit tool to monitor our progress with this plan. d) The NHA is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 3 months; at which time, we will determine the need /frequency to continue formal audits.	4/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 609	Continued From page 5 involve abuse and do not result in serious bodily injury..." Record review revealed the resident was readmitted to the facility in February of 2024 with diagnoses including, but not limited to, pressure ulcer of the sacral region (base of the spine), stage 4 (severe type of pressure ulcer, the skin is severely damaged, and the surrounding tissue begins to die [necrosis] may extend to muscle and bone), muscle weakness, and dementia. Record review of an x-ray result report dated 3/13/2024 at 3:59 PM, revealed in part, "...FINDINGS...There is a fracture of the upper portion of the patella [kneecap]..." Further record review failed to reveal evidence that the fracture, an injury of unknown origin, was reported to The Rhode Island Department of Health, per policy. During a surveyor interview on 3/14/2024 at 9:20 AM with Registered Nurse, Staff B she revealed that Resident ID #129 was transferred to an acute care hospital on 3/13/2024 after a portable x-ray revealed a fracture to his/her left knee. Staff B was unable to provide evidence that this injury of unknown origin was reported to the Rhode Island Department of Health as required.	F 609		
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.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 658	Continued From page 6 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 relative to following a physician's order for 1 of 1 resident reviewed for carbon dioxide retention, Resident ID #3, 1 of 1 resident reviewed for off-loading heel booties, Resident ID #66, 1 of 1 resident reviewed for knee splints, Resident ID #75, and 1 of 2 residents reviewed for edema (swelling), Resident ID #105. Findings are as follows: According to Mosby's 4th Edition, Fundamentals of Nursing page 314 states, "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients." 1. Record review revealed Resident ID #3 was readmitted to the facility in February of 2024 with a diagnosis including, but not limited to; chronic obstructive pulmonary disease (COPD, a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Review of a document titled "Lab Results Report" dated 2/5/2024 revealed the resident's carbon dioxide level was 37 (normal range 19-32). Review of a provider note dated 2/7/2024 states in part, "...Member also has COPD and chronic respiratory failure w/ [with] hypoxia [below-normal level of oxygen in your blood] and hypercapnia [higher than normal level of carbon dioxide in the	F 658	**As a POC for Tag F658:** a) Resident ID # 3, 66, 75 and 105 remain in the facility. We have reviewed their current orders. They are receiving care as appropriate per the orders. b) Residents who have physician orders for oxygen, off- loading devices, splints and leg elevation have the potential to be affected by this finding. We have reviewed their orders to ensure that they are being followed. We have made any needed corrections. c) We have provided education to the nurses on the importance of following physician orders and the need to ensure that they are being implemented consistently. We have stressed the need to be sure that CNAs understand their assignments and the need (for the nurses) to make frequent rounds to ensure interventions are in place. We have provided education to the CNAs to reinforce the need to follow their assignments and to let the nurse know if the assignment is unable to be carried out. We have created an audit tool to monitor our compliance with this plan. d) The Director of Nursing (DNS)/designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI Committee for no less than 3 months; at which time, we will determine the need/frequency to continue formal audits.	4/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 658	Continued From page 7 blood]; order placed to titrate O2 [oxygen] to maintain saturation 88-92%...Gave order to titrate O2 to maintain saturation of 88-92%..." Record review failed to reveal evidence of a physician's order to titrate the resident's oxygen. Record review revealed a physician's order dated 2/5/2024 for oxygen at 2-4 Liters (L) via nasal cannula, as tolerated, every shift for shortness of breath. Further record review revealed a physician order dated 2/9/2024 to keep oxygen saturation between 88-92% due to carbon dioxide retention, three times a day. Review of the February 2024 Medication Administration Record (MAR) revealed 5 out of 73 opportunities, the resident's oxygen saturation levels were documented within the indicated parameter of 88-92%. Review of the March 2024 MAR revealed 0 out of 39 opportunities, the resident's oxygen saturation levels were documented within the indicated parameter of 88-92%. Review of the resident's oxygen saturation vitals summary dated 2/8/2024 through 3/13/2024 revealed 8 out of 133 documented oxygen saturation levels were within the indicated parameter of 88-92%. During a surveyor observation on 3/13/2024 at 9:14 AM, revealed the resident was utilizing 3L of oxygen. During a surveyor observation on 3/14/2024 at	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 658	Continued From page 8 12:09 PM, in the presence of Licensed Practical Nurse (LPN), Staff C, revealed the resident was utilizing 3L of oxygen with an oxygen saturation level of 100%. During a surveyor interview, immediately following the above observation, Staff C acknowledged the resident was utilizing 3 L of oxygen, with an oxygen saturation level of 100%. She further acknowledged that the resident's oxygen saturation level of 100% does not fall within the intended parameters. During a surveyor interview on 3/14/2024 at 12:43 PM, with the Director of Nursing Services (DNS), she indicated that it is her expectation that staff would follow physician orders. A surveyor interview was attempted on 3/14/2024 at 12:43 PM with Nurse Practitioner, Staff D, but she did not answer, a voicemail was left, and the surveyor did not receive a call back. 2. Record review revealed Resident ID #66 was readmitted to the facility in September of 2022 with diagnoses including, but not limited to, stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle) of the right buttock, fusion of the spine and abnormal posture. Further record review revealed a physician's order dated 10/25/2023 for heel booties to bilateral feet every shift, as tolerated for wound care. During surveyor observations on the following dates and times the resident was observed without bilateral heel booties in place:	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 658	Continued From page 9 - 3/10/2024 at 9:18 AM - 3/10/2024 at 11:00 AM - 3/10/2024 at 12:05 PM - 3/11/2024 at 8:42 AM - 3/11/2024 at 11:14 AM - 3/11/2024 at 1:00 PM Record review failed to reveal evidence that the resident was unable to tolerate wearing the heel booties to his/her bilateral feet. During a surveyor observation and simultaneous interview on 3/11/2024 at 1:40 PM with the LPN, Staff E, she acknowledged that the resident was not wearing the bilateral heel booties. Additionally, Staff E was unable to locate one of the heel booties in the resident's room. During a surveyor interview on 3/12/2024 at approximately 9:00 AM with the DNS, she indicated that she would expect the staff to follow the physician's order. 3. Record review revealed Resident ID #75 was admitted to the facility in March of 2022 with diagnoses including, but not limited to, contracture of the right hip and right knee, stage 4 pressure ulcer of the right ankle and muscle weakness. Further record review revealed a physician's order dated 10/12/2023 for application of a right knee splint for 2 to 5 hours a day following morning care for right lower extremity contracture management. During surveyor observations on the following dates and times revealed the resident was not	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 658	Continued From page 10 wearing the right knee splint: - 3/10/2024 at 10:00 AM - 3/11/2024 at 9:18 AM - 3/11/2024 at 11:18 AM - 3/11/2024 at 1:30 PM - 3/11/2024 at 2:45 PM - 3/12/2024 at 9:00 AM - 3/12/2024 at 11:22 AM - 3/12/2024 at 2:18 PM - 3/13/2024 at 9:16 AM - 3/13/2024 at 11:30 AM - 3/13/2024 at 2:00 PM - 3/14/2024 at 9:11 AM Record review failed to reveal evidence that staff was documenting the application of the right knee splint. During a surveyor interview on 3/14/2024 at 9:24 AM with LPN, Staff F, she acknowledged that the resident did not have the right knee splint on. Additionally, she indicated that she was not aware of the right knee splint order. During a surveyor interview on 3/14/2024 at 9:36 AM with the Assistant Director of Rehabilitation, she acknowledged that there is an order for the resident to have a right knee splint, relative to his/her right knee contracture. She further indicated that the nursing staff are aware of the order and the splint is located near the window in the resident's room. During a surveyor interview on 3/14/2024 at approximately 11:00 AM with Nursing Assistant, Staff G, she stated that the resident's knee splint is applied when she has the resident on her assignment. She further revealed that it has not	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 658	Continued From page 11 been applied because she has not had the resident on her assignment since the start of the survey. 4. Record review revealed Resident ID #105 was readmitted to the facility in December of 2023 with diagnoses including, but not limited to, varicose veins of left lower extremity with ulcer of calf, open wound to left ankle and lower leg, open wound to right lower leg, and lymphedema (swelling). Record review revealed a physician's order dated 1/5/2024 to encourage leg elevation, as tolerated, every shift. Further record review revealed a physician's order dated 1/25/2024, to off-load wounds, as tolerated, every shift for wound care. During surveyor observations on the following dates and times failed to reveal evidence that the resident's wounds were off loaded or his/her legs were elevated: - 3/10/2024 at 9:17 AM - 3/10/2024 at 11:00 AM - 3/10/2024 at 12:05 PM - 3/11/2024 at 8:30 AM - 3/11/2024 at 11:45 AM - 3/11/2024 at 1:36 PM - 3/11/2024 at 2:24 PM - 3/12/2024 at 9:43 AM - 3/12/2024 at 11:29 AM - 3/12/2024 at 12:49 PM - 3/12/2024 at 2:37 PM Record review failed to reveal evidence that the resident was unable to tolerate his/her wounds	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 658	Continued From page 12 being off loaded or his/her legs being elevated. During a surveyor interview on 3/12/2024 at approximately 1:00 PM with the resident, s/he revealed that s/he has not been elevating his/her legs because staff expects him/her to elevate them in bed at all times. Additionally, s/he indicated that s/he would elevate his/her legs, but staff have not provided him/her with an alternative method to do so. S/he further indicated that s/he would like a recliner or a chair so s/he does not remain in bed all day. During a surveyor interview on 3/12/2024 at approximately 3:00 PM with LPN Staff F, she revealed that the resident has been refusing to elevate his/her legs because s/he does not like to stay in bed all day. Staff F further indicated she was not aware of the resident's preference to have a recliner in order to comply with off-loading his/her wounds and elevating his/her legs. During a surveyor interview on 3/13/2024 at 2:05 PM with the DNS, she indicated that she would expect staff to follow the physician's orders. She further stated that she was not aware of the resident not being provided a recliner or a chair to off-load his/her wounds and elevate his/her legs.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review,	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 677	Continued From page 13 and staff interview, it has been determined that the facility failed to provide the necessary services to a resident who is unable to carry out activities of daily living relative to incontinence care for 1 out of 1 incidence of incontinence care observed, Resident ID #129 and relative to the weekly scheduled showers for 9 out of 32 residents reviewed, Resident ID #s 1, 11, 38, 41, 46, 63, 82, 112, and 118. Findings are as follows: 1. Record review revealed Resident ID #129 was readmitted to the facility in February of 2024 with diagnoses including, but not limited to, pressure ulcer of the sacral region (tail bone area), stage 4 (severe type of pressure ulcer, the skin is severely damaged, and the surrounding tissue begins to die (necrosis) may extend to muscle and bone), muscle weakness, and dementia. Record review of a Minimum Data Set Assessment (MDS) dated 1/26/2024, revealed a Brief Interview for Mental Status (BIMS) score of 0 out of 15, indicating severely impaired cognition. Additionally, s/he is dependent on staff members for toileting hygiene. During a surveyor observation on 3/12/2024 at 11:11 AM, the following was revealed: - The resident was receiving assistance with transferring from his/her recliner chair to his/her bed with a mechanical lift and Nursing Assistant (NA) Staff G and NA, Staff H. - The resident was noted to be incontinent of loose stool. His/her adult incontinence brief was saturated with loose stool which extended out of	F 677	**As a POC for Tag F677:** a) Residents ID#129 does not currently reside in the facility. Residents ID# 1, 11, 38, 41, 46, 63, 82, 112, and 118 are receiving showers (if not refusing them) according to their specific care plan for ADLs. b) Residents who are dependent on staff for bathing/showering and incontinence care have the potential to be affected by this finding. We have reviewed their plans of care for bathing/showering and incontinence to ensure that these activities of daily living are being provided. We have made necessary corrections. c) We have provided education to the nursing staff regarding the importance of providing bathing/showering and incontinence care to those residents who are dependent. We have provided education related to being attentive to incontinent needs. We have reviewed the showering/bathing schedule and made needed revisions to ensure that it is followed. We have stressed with the nurses our expectations that they manage each shift to ensure that dependent residents receive the assistance required relative to incontinence care and bathing/showering. We have taken an inventory of care equipment required for showering such as shower chairs to ensure they are in working order and in sufficient quantity. We have established an audit tool to monitor our progress with this plan.	4/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 677	Continued From page 14 the brief and continued to his/her back. - The sacrum wound was covered with a dressing which was also saturated with stool. During a surveyor interview on 3/12/2024 at 11:20 AM, immediately following the above-mentioned observation with Staff G, she revealed that she was the NA assigned to provide care to Resident ID #129 for the 7:00 AM - 3:00 PM shift. She further revealed that when she arrived on shift at approximately 7:30 AM, the resident was already out of bed sitting in his/her recliner chair. Staff G indicated that she did not transfer the resident out of the recliner or provide him/her with incontinence care until the above-mentioned observation, indicating s/he sat in his/her recliner for approximately 4 hours without receiving incontinence care. During surveyor interviews on 3/12/2024 at 1:12 PM and 3/14/2024 at 11:12 AM, with the Director of Nursing Services (DNS) she revealed that she would expect staff to protect the resident's skin and check him/her at least every half to one hour for incontinence. 2. Record review revealed Resident ID #1 was readmitted to the facility in March of 2023 with diagnoses including, but not limited to, lymphedema (swelling), muscle weakness, and paranoid schizophrenia. Record review of an Annual MDS Assessment dated 5/2/2023 revealed a BIMS score of 15 out of 15, indicating intact cognition. Further review revealed that s/he requires the total assistance of two or more staff members for bathing which includes showers. Additionally, the MDS revealed	F 677	d) The DNS/designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI committee for no less than 3 months; at which time we will determine the need/frequency to continue formal audits. 4/4/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 677	Continued From page 15 that s/he answered that it is "Somewhat important," for him/her to choose his/her preferred bathing method. During a surveyor interview on 3/13/2024 at 1:14 PM with Resident ID #1, s/he revealed that s/he has not had a shower in a year because of a broken shower chair and staff do not offer him/her a shower. Additionally, s/he indicated that his/her shower days are scheduled on Tuesday and Friday during the 3:00 PM - 11:00 PM shift. S/he indicated she did not have a shower on Tuesdays 3/12/2024. Record review of the Nursing Assistant (NA) Activities of Daily Living (ADL) documentation for the dates between 2/14/2024 - 3/12/2024 failed to reveal evidence that Resident ID #1 received a shower. Additionally, the record failed to reveal evidence that s/he was offered and or refused a shower. 3. Record review revealed Resident ID #11 was admitted to the facility in April of 2011 with diagnoses including, but not limited to, unsteadiness on feet, legal blindness, and dry eye syndrome. Review of a quarterly MDS Assessment dated 11/7/2023 revealed a BIMS score of 12 out of 15, indicating moderately impaired cognition. Further review revealed that s/he requires the total assistance of 1 staff member for bathing, which includes showers. Additionally, the MDS revealed that s/he answered that it is "very important" for him/her to choose his/her preferred bathing method. During a surveyor interview on 3/11/2024 at 9:50	F 677		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 677	Continued From page 16 AM, with Resident ID #11, s/he indicated that s/he has not been given his/her scheduled shower by the NAs. Additionally, s/he revealed that they don't follow the shower schedule and s/he has to ask them about it. Further s/he revealed s/he would like to have a shower twice a week. Record review of the weekly shower schedule revealed that Resident ID #11 is scheduled to receive a shower on Tuesdays and Fridays on the 7:00 AM to 3:00 PM shift. Record review of the facility's document titled "Adls-Bathing" revealed Resident ID #11 last received a shower on 2/28/2024 at 2:59 PM. Further review revealed the resident was not showered for 7 out of 8 opportunities for a shower, from 2/13/2024 to 3/13/2024. Additionally, the record failed to reveal evidence that s/he was offered and or refused a shower. 4. Record review revealed Resident ID #38 was readmitted to the facility in October of 2018 with diagnoses including, but not limited to, unsteadiness on feet, muscle weakness, and colostomy status (a surgical opening to the abdomen to pass the stool or gas). Review of a State Optional MDS Assessment dated 2/5/2024 revealed a BIMS score of 15 out of 15, indicating intact cognition. Further review revealed that s/he requires the total assistance of 1 staff member for bathing, which includes showers. Additionally, the MDS revealed that s/he answered that it is "somewhat important" for him/her to choose his/her preferred bathing method. During a surveyor interview on 3/11/2024 at 10:00	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 677	Continued From page 17 AM, with Resident ID #38, s/he indicated that s/he would like to have a shower more often, but the staff do not offer it. Record review of the weekly shower schedule revealed that Resident ID #38 is scheduled to receive a shower on Tuesdays and Wednesdays. Record review of the facility's document titled "Adls-Bathing" for Resident ID #38 failed to reveal evidence that the resident had a shower from 2/13/2024 to 3/13/2024, missing 8 out of 8 opportunities for a shower. Additionally, the record failed to reveal evidence that s/he was offered and or refused a shower. 5. Record review revealed Resident ID #41 was readmitted to the facility in December of 2020 with diagnoses including, but not limited to, major depressive disorder, muscle weakness, and need for assistance for personal care. Review of a quarterly MDS Assessment dated 12/26/2023 revealed a BIMS score of 7 out of 15, indicating severely impaired cognition. Further review revealed that s/he requires the total assistance of 1 staff member for bathing, which includes showers. Additionally, the MDS revealed that s/he answered that it is "somewhat important" for him/her to choose his/her preferred bathing method. During a surveyor interview on 3/11/2024 at 10:16 AM, with Resident ID #41, s/he indicated that s/he would like to have a shower and have his/her hair washed to feel good. Additionally, s/he revealed that they only give him/her a sponge bath. S/he further indicated that when s/he requests a shower, the NAs tell him/her the following shift will	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 677	Continued From page 18 assist him/her with a shower. Record review of the resident's weekly shower schedule revealed that s/he is scheduled to receive a shower on Mondays and Thursdays on the 3:00 PM to 11:00 PM shift. Record review of the facility's document titled "Adls-Bathing" revealed Resident ID #41 received a shower on 2/15/2024, 2/27/2024 and on 3/7/2024 missing 5 out 8 opportunities from 2/13/2024 to 3/13/2024. Additionally, the record failed to reveal evidence that s/he was offered and or refused a shower. 6. Record review revealed Resident ID #46 was readmitted to the facility in March of 2024 with diagnoses including, but not limited to, mood disorder, skin excoriation disorder and shortness of breath. Review of a quarterly MDS Assessment dated 12/14/2023 revealed a BIMS score of 15 out of 15, indicating intact cognition. Further review revealed that s/he requires the total assistance of 1 staff member for bathing, which includes showers. Additionally, the MDS revealed that s/he answered that it is "somewhat important" for him/her to choose his/her preferred bathing method. During a surveyor interview on 3/11/2024 at 10:22 AM, with Resident ID #46, s/he indicated that even though s/he has trouble breathing sometimes, s/he would like to have a shower. Additionally, s/he revealed that the staff do not ask nor follow the twice a week shower schedule and when s/he asks staff for a shower, they make it difficult and still do not provide him/her with a	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 677	Continued From page 19 shower. Record review of the weekly shower schedule revealed that Resident ID #46 is scheduled to receive a shower on Tuesdays and Fridays on the 7:00 AM to 3:00 PM shift. Record review of the facility's document titled "Adls-Bathing" revealed Resident ID #46 did not receive a shower from 2/13/2024 to 3/13/2024, missing 8 out of 8 opportunities for a shower. Additionally, the record failed to reveal evidence that s/he was offered and or refused a shower. 7. Record review revealed Resident ID #63 was admitted to the facility in October of 2023 with diagnoses including, but not limited to, major depressive disorder, insomnia, and muscle weakness. Review of a quarterly MDS Assessment dated 1/30/2024 revealed a BIMS score of 15 out of 15, indicating intact cognition. Further review revealed that s/he requires the total assistance of 1 staff member for bathing, which includes showers. Additionally, the MDS revealed that s/he answered that it is "somewhat important" for him/her to choose his/her preferred bathing method. During a surveyor interview on 3/11/2024 at 9:32 AM, with Resident ID #63, s/he indicated that s/he does not take shower because the shower room floor has mold and cracked tiles on it. S/he further revealed that staff do not offer him/her a shower. Record review of the shower schedule revealed that Resident ID #63 is scheduled to receive a shower on the 3:00 PM to 11:00 PM shift but it	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 677	Continued From page 20 failed to reveal what days the resident was scheduled to receive a shower. Record review of the facility's document titled "Adls-Bathing" revealed Resident ID #63 did not receive a shower from 2/13/2024 to 3/13/2024, missing 8 out of 8 opportunities for a shower. Additionally, the record failed to reveal evidence that s/he was offered and or refused a shower. 8. Resident ID #82 was readmitted to the facility in June of 2023 with diagnoses including, but not limited to, diabetes and major depressive disorder. Record review of a Significant Change in Status MDS Assessment dated 6/24/2023, revealed a BIMS score of 5 out of 15, indicating severely impaired cognition. Further review revealed that s/he requires the total assistance of one staff member for bathing, which includes showers. Additionally, the MDS revealed that it is "Somewhat important," for him/her to choose his/her preferred bathing method. During a surveyor interview on 3/13/2024 at 1:49 PM, with Resident ID #82, s/he revealed that s/he has never been offered or received a shower. Record review of the ADL documentation between 2/14/2024 to 3/12/2024 failed reveal evidence that s/he received a shower. Additionally, the record failed to reveal evidence that s/he was offered and or refused a shower. 9. Record review revealed Resident ID #112 was admitted to the facility in January of 2024 with diagnoses including, but not limited to, chronic obstructive pulmonary disease and pain in lower	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 677	Continued From page 21 leg. Review of an Admission MDS Assessment dated 1/31/2024 revealed a BIMS score of 13 out of 15, indicating intact cognition. Further review revealed s/he requires substantial/maximal assistance of staff for bathing, which includes showers. Additionally, the MDS revealed that it is "Somewhat important, for him/her to choose his/her preferred bathing method". During a surveyor interview on 3/11/2024 at 11:28 AM with Resident ID #112, s/he revealed that s/he hasn't received a shower in a couple of weeks and it bothers him/her. S/he further revealed that his/her hair is a mess and feels knotted from not taking a shower. During a surveyor interview on Wednesday, 3/13/2024 at 11:19 AM with NA, Staff I, in the presence of NA, Staff J, she revealed that the resident told her this morning that s/he had asked for a shower. Staff J revealed that the resident's shower schedule is on Mondays and Thursdays. Record review of the ADL documentation between 2/1/2024 to 3/13/2024 revealed that Resident ID #112 received one shower on 2/23/2024, indicating s/he missed 7 out of 8 opportunities to receive a shower. Further review of the documentation revealed the resident did not receive a shower on 3/13/2024, after bringing it the attention to Staff I. Additionally, the record failed to reveal evidence that s/he was offered and or refused showers. 10. Record review revealed Resident ID #118 was readmitted to the facility in September of 2013 with diagnoses including, but not limited to,	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 677	Continued From page 22 legal blindness, major depressive disorder, and anxiety disorder. Review of a quarterly MDS Assessment dated 1/17/2024 revealed a BIMS score of 11 out of 15, indicating moderately impaired cognition. Further review revealed that s/he requires the total assistance of 1 staff member for bathing, which includes showers. Additionally, the MDS revealed that s/he answered that it is "somewhat important" for him/her to choose his/her preferred bathing method. During a surveyor interview on 3/11/2024 at approximately 11:00 AM, with Resident ID #118, s/he indicated that the staff do not help him/her take shower, even though s/he is aware of the schedule that they are supposed to follow. Additionally, Resident ID #118 revealed that s/he must "fight" with the NAs most of the times to help him/her with a shower, even when s/he has his/her concerns with personal hygiene. Record review of the weekly shower schedule revealed that ID #118 is scheduled to received daily showers. Record review of the facility's document titled "Adls-Bathing" revealed Resident ID #118 received a shower on 3/2/2024 and 3/7/2024, indicating s/he missed 28 out of 30 opportunities for a shower, from 2/13/2024 to 3/13/2024. Additionally, the record failed to reveal evidence that s/he was offered and or refused a shower. During a surveyor interview on 3/12/2024 at approximately 1:30 PM with the Lead NA, Staff K, she was unable to provide evidence that these residents shower schedules were being followed	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 677	Continued From page 23 by the staff. During a surveyor interview 3/13/2024 at approximately 3:00 PM with the DNS, she indicated that she would expect staff to give the residents a shower according to their schedule. Additionally, she was unable to provide evidence that the facility provided the necessary services to a resident who is unable to carry out activities of daily living.	F 677		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide necessary treatment and services, consistent with professional standards of practice, to promote wound healing and prevent new ulcers from developing for 1 of 3 wound treatments observed, Resident ID #129. Findings are as follows:	F 686	**As a POC for Tag F686:** a) Resident ID#129 has since been discharged. The issues noted in the 2567 were addressed timely upon our awareness of the situation. b) We have subsequently reviewed all residents with pressure areas and the weekly body checks in order to ensure any pressure areas have been documented to include evidence of measurement & description as well as notification to MD, treatment orders, and implementation of any care plan interventions (i.e. pressure-relieving devices) to include timely execution.	4/24/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 686	Continued From page 24 Record review of an undated facility policy titled, "Wounds - Dressing Changes," states in part, "...This policy and procedure intent is to ensure that...resident's skin integrity is addressed appropriately. Dressing changes will be done based on the physician orders using clean dressing change procedure...1. Upon discovery of a new skin integrity issue, the nurse will...Assess and measure the wound...The charge nurse will notify the physician, resident representative...and wound nurse...Order entered for treatment for wound...Nurse note written with a description of alteration in skin integrity, treatment initiated, and notification to the physician..." Review of the facility policy, revised on 3/12/2022 titled, "Skin Care Protocol," states in part, "...For those residents identified as 'at risk' interventions must be carried out in a timely manner. Interventions to consider include but may not be limited to...Pressure-relieving...cushion...Repositioning... Minimize exposure to moisture; keep resident dry and clean..." Record review revealed the resident was readmitted to the facility in February of 2024 with diagnoses including, but not limited to, pressure ulcer of the sacral region (tail bone area), stage 4 (severe type of pressure ulcer, the skin is severely damaged, and the surrounding tissue begins to die [necrosis] may extend to muscle and bone), muscle weakness, and dementia. Record review of a Minimum Data Set Assessment (MDS) dated 1/26/2024, revealed a Brief Interview for Mental Status score of 0 out of 15, indicating severely impaired cognition.	F 686	c) We have conducted root-cause-analysis (RCA) to identify the causative factors of the issue. The nursing management team is providing the nurses with competency-based training and (re)education regarding the importance of complying with the regulations regarding pressure injury/wound documentation, treatment, and executing of the plan of care. The interdisciplinary team (IDT) will review those residents with pressure areas/wounds at the weekly Risk meeting to ensure proper documentation, notification to MD and execution of the treatment plan is evident and has occurred timely. We will also review weekly body check documentation to ensure any new areas are responded to timely and properly. d) The DNS/designee is responsible for ensuring this POC is executed timely and effectively. We will conduct ongoing audits of pressure areas and weekly body checks to monitor our improvement efforts. The audits will be shared with the QAPI Committee monthly for no less than three months, after which time the QAPI Committee will evaluate our level of compliance/improvement and determine if we will "drop" the indicator or continue.	4/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 686	Continued From page 25 Additionally, s/he does not walk and is dependent on staff members for mobility which includes transferring from bed to chair. The MDS assessment further revealed that the resident was admitted to the facility with the stage 4 pressure area to his/her sacrum area. It is documented that the treatment included, but is not limited to, a "...Pressure reducing device for chair..." Additional record review revealed a care plan dated 1/15/2024, which indicates that the resident has a pressure ulcer to his/her sacrum area and has the potential for pressure ulcer development related to immobility. Interventions include, but are not limited to, follow the facility policies and protocols for the prevention and treatment of skin breakdown. Further review of the care plan did not identify any additional pressure areas. During a surveyor observation on 3/12/2024 at 11:11 AM, the following was revealed: - The resident was receiving assistance with transferring from his/her recliner chair to his/her bed with a mechanical lift and Nursing Assistant (NA), Staff G and by Staff H. - The resident was noted to be incontinent of loose stool. His/her adult incontinence brief was saturated with loose stool which extended out of the brief and continued to his/her back. - The sacrum wound was covered with a dressing which was also saturated with stool. - A white, soiled adhesive dressing was observed to his/her right lower buttocks area (ischium).	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 686	Continued From page 26 - There was no cushion observed to his/her recliner chair. - A non-blanchable (discoloration of the skin that does not turn white when pressed) red/purple area was observed to his/her right hip and left lateral thigh. During a surveyor interview on 3/12/2024 at 11:20 AM, immediately following the above-mentioned observation with Staff G, she revealed that she was the NA assigned to provide care for Resident ID #129 during the 7:00 AM to 3:00 PM shift. She further revealed that when she arrived on shift at approximately 7:30 AM, the resident was already out of bed sitting in his/her recliner chair. Staff G indicated that she did not transfer the resident out of the recliner or provide him/her with incontinence care until the above-mentioned observation, indicating s/he sat in his/her recliner for approximately 4 hours. Record review revealed the following physician's orders relative to the resident's skin conditions: - 1/17/2024, Body check weekly every Wednesday evening - 2/15/2024, Off load wound; reposition as tolerated every shift - 2/23/2023, Coccyx [sacrum] wound to be cleansed with ¼ strength Dakins (a solution used to treat or prevent wound infections) moisten kerlix (bandage) with Dakins and gently pack the wound, cover with island border gauze twice daily and as needed every day and evening shift. During a surveyor interview on 3/12/2024 at 11:36	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 686	Continued From page 27 AM with Licensed Practical Nurse, Staff L, she revealed that the resident was out of bed sitting in his/her recliner chair when she arrived on shift at approximately 7:30 AM. Additionally, she was unable to say if the non-blanchable areas noted to the resident's right hip and lateral left thigh were new. Furthermore, she was unable to explain why a dressing was in place to the resident's right ischium without a physician's order. Further record review failed to reveal evidence that the areas to Resident ID #129's right hip, left lateral thigh and right ischium existed prior to this observation. Furthermore, the record revealed that the weekly body check was conducted on 3/6/2024 on the Treatment Administration Record (TAR) , however, the record failed to reveal documentation of the findings. During a surveyor observation and simultaneous interview on 3/12/2024 at 12:20 PM with the Wound Physician and the facility's Wound Nurse/Infection Preventionist revealed the following: The wound physician revealed that he would expect that a pressure reducing device would be in place to Resident ID #129's chair. Additionally, he would expect staff to reposition the resident at least every 2 hours. He also acknowledged that the wounds to Resident ID #129's right hip, left lateral thigh, and right ischium were new. Further record review failed to reveal evidence that the physician was notified of the wound to the resident's right ischium. During a surveyor interview on 3/14/2024 at 9:20	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 686	Continued From page 28 AM, with Registered Nurse (RN), Staff B, she revealed that she found the wound to the resident's right ischium on 3/11/2024. Staff B acknowledged that she did not document the wound description or obtain measurements of the wound. Furthermore, she revealed that she failed to notify the physician and obtain treatment orders prior to applying a treatment to the resident's right ischium wound. During surveyor interviews on 3/12/2024 at 1:12 PM and 3/14/2024 at 11:12 AM with the Director of Nursing Services, she revealed that she would expect staff to protect the resident's skin and check him/her at least every half to one hour and report any new areas to the physician and the resident's family. She also indicated that she would expect documentation of a weekly body check findings to be in the progress notes as well as signed off on the (TAR). Furthermore, she revealed that she was the assigned nurse for Resident ID #129 on 3/6/2024 during the 3:00 PM - 11:00 PM shift and revealed that she documented his/her weekly body check findings as a late entry on 3/13/2024, after it was brought to her attention by the surveyor.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690	**As a POC for Tag F690:** a) Residents ID#129 does not currently reside in the facility. ID#79 is receiving appropriate indwelling catheter and nephrostomy tube care to include monitoring of output. b) Residents who have indwelling catheters and nephrostomy tubes have the potential to be affected by this finding. We have reviewed their physicians' orders and plans of care to ensure they are receiving appropriate care. Any needed corrections will be made.	4/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 690	Continued From page 29 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to provide appropriate treatment and services for 2 of 5 residents reviewed with an indwelling catheter (a flexible tube that collects urine from the bladder and leads to a drainage bag), Resident ID #s 79 and 129. Findings are as follows: According to Brunner & Suddarth's Textbook of Medical-Surgical Nursing Volume 2, 10th Edition,	F 690	c) We have provided education to the nurses on the need to review, verify and implement physician orders upon a resident's admission/readmission, to ensure that all necessary orders are in place and specifically orders for the care and maintenance of a nephrostomy tube and foley catheter. We have reviewed our protocols for monitoring urinary output for residents with urinary catheters as well as those with nephrostomy tubes and the importance of consistent documentation. We have instructed the CNAs on their responsibility to empty urinary collection bags and report any unusual findings to the nurse. We have devised an audit tool to determine compliance with this plan. d) The DNS/designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI committee for no less than 3 months; at which time, we will determine the need/frequency to continue formal audits.	4/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 690	Continued From page 30 page 252 states "the usual daily urine volume in the adult is 1-2 Liters or 1000-2000 cubic centimeters (cc)." According to Brunner & Suddarth's Textbook of Medical-Surgical Nursing Volume 2, 10th Edition, page 1282 states, "For patients with indwelling catheters, the nurse assesses the drainage system to ensure that it provides adequate urinary drainage. The color, odor, and volume of urine are also monitored. An accurate record of fluid intake and urine output provides essential information about the adequacy of renal function and urinary drainage." 1. Record review revealed Resident ID #79 was readmitted to the facility in February of 2024 with diagnoses including, but not limited to, retention of urine and obstructive and reflux uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional). Further record review revealed the resident was hospitalized from 2/29/2024 to 3/4/2024 when s/he returned to the facility. Review of the resident's care plan revealed a focus initiated on 6/16/2023 and revised on 2/7/2024 that revealed the resident has an indwelling catheter in place related to obstructive uropathy and kidney stones. An intervention includes, but is not limited to, monitor and document intake and output as per facility policy. Record review revealed the resident has a percutaneous nephrostomy tube (PCN, a tube that is inserted through a small surgical incision in the skin and runs from the kidney to a valve,	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 690	Continued From page 31 which connects to a drainage bag that collects urine). Record review revealed the following physician orders: - Flush catheter with 60 cc of sterile water, with a start date of 7/3/2023 and a hold date of 3/2/2024. - Flush PCN tube with 10 cc of normal saline, change outer dressing with each flush, every Tuesday, Friday, and Saturday day shift, for PCN maintenance and monitor output, with a start date of 2/9/2024 and a hold date of 3/2/2024. Further record review failed to reveal evidence that the above orders were re-initiated upon the residents return to the facility on 3/4/2024, until it was brought to the facility's attention by the surveyor on 3/12/2024. Additional record review failed to reveal documentation of urinary output for the month of March 2024, to monitor for urine output. During a surveyor interview on 3/12/2024 at 11:33 AM, with Licensed Practical Nurse (LPN), Staff M, she revealed that the resident did not have any recommendations or orders from the physician to empty the resident's PCN drainage bag or record urinary output. Further, she revealed that she does not empty the PCN drainage bag and indicated that the Nursing Assistants (NA) will tell her if it needs to be emptied. During a subsequent interview on 3/12/2024 at 11:35 AM, with NA, Staff I, in the presence of Staff M, she revealed that she does not have the ability to chart the resident's urinary output and	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 690	Continued From page 32 indicated that it should be documented every shift. Additionally, both Staff I and Staff M acknowledged that there is no documentation of urinary output from the resident's catheter or PCN tube. During a surveyor interview on 3/12/2024 at 12:26 PM, with the Assistant Director of Nursing Services, she revealed that the physician's orders to flush the foley catheter and PCN tube should not have been on hold, after the resident returned from the hospital and indicated she told the provider, after it was brought to her attention by the surveyor. Additionally, she acknowledged that there are no measurements for the output of the foley catheter or PCN tube in the resident's record. During a surveyor interview on 3/12/2024 at 1:22 PM, with the Director of Nursing Services (DNS), she revealed that the urinary output of the resident's foley catheter and PCN tube should be documented in his/her record. Further, she indicated that she would have expected the physician orders, relative to flushing the foley catheter and PCN tube, to have been reinstated after the resident was hospitalized, given the resident's history of having multiple blockages in them. 2. Record review revealed Resident ID #129 was admitted to the facility in January of 2024 with diagnoses including, but not limited to, urinary tract infection and obstructive and reflux uropathy. Review of the resident's care plan revealed a focus area last revised on 1/24/2024 that revealed the resident has a foley catheter due to	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 690	Continued From page 33 obstructive uropathy. Record review failed to reveal documentation of urinary output, to monitor for urine output. During a surveyor interview on 3/14/2024 at 11:16 AM, with the DNS, she acknowledged that the resident does not have a physician's order to monitor urinary output. She further revealed that the nurses should be monitoring the urinary output, but indicated they only have to document urinary output if there is a physician's order. Furthermore, she was unable to explain how staff are monitoring the day to day urinary output for residents with a diagnosis of obstructive and reflux uropathy if there is not documentation in their records to review.	F 690		
F 692 SS=G	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 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;	F 692	**As a POC for Tag F692:** a) Resident ID#129 has since been discharged from our facility. Resident ID#98 is stable with interventions in place and the MD has been notified of the weight variance. b) Our clinical team has since reviewed any other residents who may be experiencing a change in condition (specifically related to weight variances) so as to ensure the Physician and Representative (when applicable) have been notified in a timely manner of the situation and interventions executed timely. We are following up accordingly.	4/14/24

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 692	Continued From page 34 §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 ensure that residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range for 2 of 11 residents reviewed for nutrition, Resident ID #s 98 and 129. Findings are as follows: Review of a facility policy titled, "Weight Monitoring Policy" dated 2/24/2017, states in part, " ...All residents are to be weighed on a monthly basis between the first and the sixth of the month...If the weight is +/- [greater than/less than] 3 pounds from the previous weekly weight or +/- 5% on a monthly the resident is to be removed from the scale and reweighed (this needs to be done no later than within 24 hours for the questionable weight)...The dietician will review the weights and determine if additional intervention may need to be added..." 1. Record review revealed that Resident ID #98 was readmitted to the facility in February of 2024 with diagnoses of, but not limited to, mild neurocognitive disorder and acute kidney failure. Review of the "Weights and Vitals Summary Report" revealed the following weights: 2/6/2024 - 136.2 pounds (lbs) 2/27/2024 - 128.6 lbs Review of the progress notes revealed the	F 692	c) We have conducted RCA to identify the causative factors leading to the issue of noncompliance. The nurses have been re-educated on the policies associated with response to weight variances. Our clinical team will review those residents experiencing a weight variance at our morning meeting and Risk meetings to ensure optimal awareness of the situation and optimal communication to all members of the team (to include the Physician and Resident Representative when applicable). The IDT is also reviewing weight variances with our MDs/NPs and PAs on a routine basis. d) The DNS/designee will conduct routine chart audits/observations of residents experiencing a weight variances to ensure timely notification and response has been made. Our audit findings will be submitted to the QAPI Committee monthly for a period of no less than 3 months, after which time, the QAPI Committee will determine the need to continue audits based on our level of progress and compliance with systemic changes.	4/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 692	Continued From page 35 Dietician made the following recommendations on 2/28/2024: Notify the doctor of weight loss and poor appetite, question using an appetite stimulant, add 8-ounce house supplement two times per day. Record review failed to reveal evidence that an appetite stimulant or a house supplement was initiated per the dietician's recommendations. Further review of the resident's recorded weights revealed a weight on 3/12/2024 of 125 lbs, indicating the resident experienced an additional 3.6 lb weight loss in the 14 days following the dietician's recommendations that were never implemented. During a surveyor interview on 3/13/2024 at 8:20 AM with the Registered Dietician, she acknowledged that neither the appetite stimulant or the house supplement had been initiated for the resident. Additionally, she acknowledged the resident continued to lose weight. During a surveyor interview on 3/13/2024 at 10:08 AM via telephone with Nurse Practitioner, Staff N, she revealed that she was never made aware of the dietician's recommendations. Additionally, she revealed that she would have ordered both an appetite stimulant and a supplement for the resident if she had been made aware. During a surveyor interview on 3/13/2024 at approximately 2:00 PM with the Director of Nursing Services (DNS) she revealed that she would expect the staff to report the Dieticians recommendations to the provider and obtain orders.	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 692	Continued From page 36 2. Review of a facility provided document titled, "March 2024 Monthly Weights" states, "reweigh all residents with a 3 pound difference immediately. Weight due by the 6th of each month." Record review revealed that Resident ID #129 was readmitted to the facility in February of 2024 with diagnoses including, but not limited to, dementia and atrial fibrillation (abnormal heart rate). Record review revealed the resident's weight was 169 lbs on 2/11/2024. Review of the "March 2024 Monthly Weights" revealed the resident's weight was 188.4 lbs. A weight gain of 19.4 lbs or 11.8%. Record review failed to reveal evidence of a re-weight per the facility policy. Further review failed to reveal evidence that the resident's provider or dietician were notified of his/her weight gain per the facility policy. Review of an Admission Minimum Data Set Assessment dated 1/26/2024 revealed that the resident is at nutritional risk and would require a nutrition care plan. Record review failed to reveal evidence that a care plan was initiated for the resident to address his/her nutritional risk. During a surveyor interview on 3/13/2024 at 9:35 AM with the Registered Dietician she acknowledged that a nutritional care plan was not initiated to address the resident's nutrition risk.	F 692		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 692	Continued From page 37 Additionally, she was unaware of the residents 19.4 lb weight gain since the previous month. During a surveyor interview on 3/13/2024 at 2:09 PM with the DNS, she was unable to provide evidence of a reweight or notification to the physician and dietician of the weight gain per the policy. Additionally, she was unable to provide evidence that the facility ensured that residents maintain acceptable parameters of nutritional status for the above-mentioned residents.	F 692		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interviews, it has been determined that the facility failed to ensure that pain management was provided to a resident who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 3 wound treatments observed, Resident ID #79. Findings are as follows: According to the "State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities" last revised on 2/3/2023 states in part, "...Because pain can significantly	F 697	**As a POC for Tag F697:** a) Resident ID#79 is being medicated for pain prior to the wound dressing being completed. We will monitor the effectiveness of the pain medication and respond accordingly to any changes in the plan of care that may need to be made. b) We have since reviewed all residents with wounds for assurances that pain associated with the wound/dressing change is being monitored and treated accordingly.	4/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 697	Continued From page 38 affect a person's well-being, it is important that the facility recognize and address pain promptly. The facility's evaluation of the resident at admission and during ongoing assessments helps identify the resident who is experiencing pain or for whom pain may be anticipated during specific procedures, care, or treatment..." Record review revealed the resident was re-admitted to the facility in March of 2024 with diagnoses including, but not limited to, sepsis (an infection in the blood stream) and epilepsy. Review of a document titled, "WOUND EVALUATION & MANAGEMENT SUMMARY" dated 3/12/2024, revealed the resident has a stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle) to his/her sacrum (base of the spine) measuring 5 centimeters (cm) by 1.9 cm by 1 cm. Further review revealed a recommendation to administer pain medication prior to wound care. During a surveyor observation on 3/13/2024 at approximately 9:16 AM, revealed Licensed Practical Nurse, Staff M, performing wound care of the resident's stage 4 pressure ulcer. Throughout the duration of the wound treatment, the resident was noted to be yelling, swearing, and complaining of pain. Further, the nurse proceeded with the wound treatment and did not stop until the treatment was completed. During a surveyor interview on 3/13/2024 at 9:18 AM, with Staff M, she revealed that the resident does not have any pain medication available and further indicated that the resident is only in pain during wound treatments.	F 697	c) We have conducted RCA as part of our action plan related to the issues regarding wound care and pain was a part of that review. Our wound champion (nurse) and the charge nurses per unit are reviewing all residents with wound treatments to identify those residents who have pain associated with the wound; assurances of an order for pain medication is evident and a care plan addressing the issue are also being reviewed and confirmed. We are conducting competency-based training for the nurses to ensure they are knowledgeable of the need to evaluate pain when a resident has a wound. The IDT will review those residents with wounds and/or pain at our weekly Risk meeting to ensure an effective plan of care is in place and/or revised. d) The DNS/designee will conduct routine chart audits/observations of residents with wounds to ensure timely the plan of care (to include pain management) is being carried out. Our audit findings will be submitted to the QAPI Committee monthly for a period of no less than 3 months, after which time, the QAPI Committee will determine the need to continue audits based on our level of progress and compliance with systemic changes.	4/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 697	Continued From page 39 During a subsequent interview on 3/13/2024 at 9:21 AM, with Staff M, she acknowledged the resident did not receive any pain medication prior to the observed wound treatment. She further revealed that she does not medicate the resident before wound treatments. Record review revealed a physician's order dated 6/14/2023 for Acetaminophen tablet, 650 milligrams, every six hours, as needed for temperature and pain. Review of the March 2024 Medication Administration Record failed to reveal evidence that the above pain medication was administered to the resident on 3/13/2024, prior to his/her wound treatment. During a surveyor interview on 3/13/2024 at 1:59 PM, with the Director of Nursing Services, she indicated that she would expect the resident to be medicated for pain prior to wound treatments. She further revealed that she would have expected the nurse to stop the wound treatment and administer the resident pain medication.	F 697		
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 each resident's	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 759	Continued From page 40 medication regimen is free from a medication error rate of 5% or greater. Based on 25 opportunities for errors observed during the medication administration task there were 2 errors resulting in an error rate of 8%, involving Resident ID #s 7 and 86. Findings are as follows: 1. Record review revealed Resident ID #86 has a physician's order for Eliquis 5 milligrams give 1 tablet every morning and night related to septic pulmonary embolism (infected blood clot in the lung). During a surveyor observation of the medication administration task on 3/11/2024 at 10:15 AM with Registered Nurse, Staff O, she failed to administer the morning dose of Eliquis to the resident as ordered. During a surveyor interview immediately following the above observation with Staff O, she acknowledged that Resident ID #86 did not receive his/her Eliquis. 2. Record review revealed Resident ID #7 has a physician's order for Fluticasone Proprionate nasal suspension 50 micrograms give 1 spray in each nostril in the morning for nasal congestion. Further surveyor observation of the medication administration task on 3/11/2024 at approximately 10:30 AM with Staff O, she failed to administer the above medication to Resident ID #7 as ordered. During a surveyor interview immediately following the above observation with Staff O, she	F 759	**As a POC for Tag F759:** a) Resident ID#7 and 86 did not exhibit any negative effects due to of the medication omissions. b) Residents who reside in the facility have the potential to be affected by this finding. We are monitoring medication pass to ensure physician medication orders are being followed. c) We have educated the nurses on the importance of accuracy during the medication pass. We have instructed them on the need to review and double check the EMAR carefully to ensure that all medications for that medication time have been administered before moving on to the next resident. The potential for a negative outcome due to a medication omission was emphasized. An audit has been developed to monitor compliance with this plan. d) The DNS/designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 3 months; at which time, we will determine the need/frequency to continue formal audits.	4/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 759	Continued From page 41 acknowledged that Resident ID #7 did not receive his/her Fluticasone. During a surveyor interview with the Director of Nursing Services on 3/12/2024 at 1:44 PM, she revealed that she would expect that the residents receive their medication as ordered. Additionally, she was unable to provide evidence that the facility ensured each resident's medication regimen is free from a medication error rate of 5% or greater.	F 759		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it has been determined that the facility failed to keep residents free from significant medication errors for 6 of 32 residents reviewed, Resident ID #s 7, 42, 48, 70, 112 and 123. Findings are as follows: Review of a facility policy titled, "Medication Administration" states, "It is the intent of this policy to ensure that resident medication administration is managed to ensure for resident quality of life, timeliness and safety." 1. Record review revealed Resident ID #48 was readmitted to the facility in December of 2020 with diagnoses including, but not limited to, schizoaffective disorder and borderline personality disorder.	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 760	Continued From page 42 Record review revealed the following physician orders: Ambien oral tablet 5 milligram (MG, hypnotic), give 1 tablet by mouth at bedtime for insomnia. Oxycodone oral tablet 10 MG, give one tablet by mouth every 6 hours for pain. Review of the March 2024 Medication Administration Record (MAR) revealed the medication was not administered and coded as 9, (see nurses note) on the following dates: Ambien on 3/6, 3/7, 3/8, 3/9, 3/10 and 3/11/2024 Oxycodone on 3/1, 3/2, 3/3, 3/4 and 3/12/2024 Review of the progress notes on the above-mentioned dates revealed the medications were unavailable to be administered. During a surveyor interview on 3/12/2024 at 10:08 AM with Nurse Practitioner (NP), Staff P, she revealed that she was not aware of the resident not receiving the above-mentioned medications until 3/12/2024. 2. Record review revealed that Resident ID #7 was admitted to the facility in December of 2022 with diagnoses including, but not limited to, anxiety and adult failure to thrive. Record review revealed the following physician orders: Lexapro oral tablet 10 MG, give 1 tablet by mouth in the morning for anxiety.	F 760	**As a POC for Tag F760:** a) There were no untoward effects from the omission of medications for Residents ID#7, 42, 48, 70, 112, and 123. Their providers were notified of the unavailability of the prescribed medications on the identified dates. b) All residents have the potential to be affected by this finding. We have reviewed the EMAR documentation to ensure medications were administered as prescribed. Providers will be notified of non- availability of medications as necessary. c) We have provided education to the nurses on the process of medication reordering and how to do it in a timely manner to eliminate/minimize the unavailability of medications. We have further instructed them on alternatives (such as an emergency box) within the facility if medication is not available. We have instructed them on the need to report to the physician when medication orders cannot be followed due to unavailability. We have further educated them on the need to consult with the physician regarding alternatives orders. We have developed an audit tool to monitor our compliance with this plan. d) The DNS/designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 3 months; at which time, we will determine the need/frequency to continue formal audits.	4/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 760	Continued From page 43 Fluticasone Propionate Nasal Suspension 50 MCG/ACT (micrograms/activation), 1 spray in each nostril in the morning for nasal congestion. Artificial Tears Ophthalmic Solution, instill 1 drop in both eyes every morning and at bedtime for dry eyes. Review of the March 2024 MAR revealed the following medications were not administered and coded as 9 (see nurses note) on the following dates: Lexapro oral tablet 10 MG on 3/3 and 3/4/2024 Artificial Tears Ophthalmic Solution on 3/4, 3/5, 3/6, 3/7, and 3/9/2024 Fluticasone Propionate Nasal Suspension 50 MCG/ACT on 3/8 and 3/11/2024 Review of the progress notes on the above-mentioned dates revealed the medications were unavailable to be administered. Record review failed to reveal evidence that the practitioner was notified of the above noted missed medications. 3. Record review revealed that Resident ID #42 was readmitted to the facility in March of 2020 with diagnoses including, but not limited to, schizophrenia and major depressive disorder. Record review revealed the following physician orders: Zoloft Tablet 100 MG, give 1 tablet by mouth in	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 760	Continued From page 44 the morning for depression. Review of the March 2024 MAR revealed the following medication was not administered and coded as 9 (see nurses note) on the following dates: Zoloft on 3/6 and 3/7/2024 Review of the progress notes on the above-mentioned dates revealed the medication was unavailable to be administered. Record review failed to reveal evidence that the practitioner was notified of the above noted missed doses of medication until after it was brought to the facility's attention by the surveyor. 4. Record review revealed that Resident ID #70 was readmitted to the facility in February of 2024 with diagnoses including, but not limited to, hypertension and schizoaffective disorder. Record review revealed the following physician orders: Carvedilol (antihypertensive) Oral Tablet 3.125 MG, give 1 tablet by mouth two times a day for hypertension. Hypromellose Ophthalmic Solution, instill 1 drop in both eyes three times a day for dry eyes. Review of the March 2024 MAR revealed the following medications were not administered and coded as 9 (see nurses note) on the following dates: Carvedilol Oral Tablet 3.125 MG on 3/3/2024 and	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 760	Continued From page 45 3/4/2024 Hypromellose Ophthalmic Solution on 3/1, 3/2, 3/4, 3/5, 3/6, 3/7, and 3/9/2024 Review of the progress notes on the above mentioned dates revealed the medications were unavailable to be administered. Record review failed to reveal evidence that the practitioner was notified of the above noted missed doses of medications. 5. Record review revealed that Resident ID #112 was readmitted to the facility in January of 2024 with diagnoses including, but not limited to, anxiety disorder and major depressive disorder. Record review revealed the following physician order: Lorazepam oral tablet 0.5 MG, give 1 tablet one time a day for anxiety disorder. Review of the March 2024 MAR revealed the following medication was not administered and coded as 9 (see nurses note) on the following dates: Lorazepam Oral Tablet 0.5 MG on 3/9 and 3/10/2024 Review of the progress notes on the above-mentioned dates revealed the medication was unavailable to be administered. Record review failed to reveal evidence that the practitioner was notified of the above noted missed doses of medication.	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 760	Continued From page 46 6. Record review revealed that Resident ID #123 was admitted to the facility in September of 2022 with diagnoses including, but not limited to, anxiety disorder and traumatic brain injury. Record review revealed the following physician orders: Buspirone oral tablet 5 MG, give 1 tablet two times a day related to anxiety. Review of the March 2024 MAR revealed the following medication was not administered and coded as 9 (see nurses note) on the following dates: Buspirone 5 MG, the AM dose on 3/1 and 3/2/2024 and the PM dose on 3/3/2024 Review of the progress notes on the above mentioned dates revealed the medication was unavailable to be administered. Record review failed to reveal evidence that the practitioner was notified of the above noted missed doses of medication. During a surveyor interview on 3/12/2024 at 9:56 AM with Licensed Practical Nurse, Staff M, she revealed that the facility does have an emergency kit available to utilize if medications do not come in from the pharmacy timely. Additionally, she acknowledged that the above medication was not administered as ordered and there is no evidence of the provider being notified. During a surveyor interview on 3/12/2024 at 1:39 PM with the Director of Nursing Services she	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 760	Continued From page 47 acknowledged that the above-mentioned medications were not administered and coded as not available. Additionally, she was unable to provide evidence that the facility kept residents free from significant medication errors.	F 760		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that food is stored and distributed, in accordance with professional standards for food safety relative to the main kitchen and 2 of 2 ice machines. Findings are as follows:	F 812	**As a POC for Tag F812** a) No residents were named in this citation. b) Residents who reside in the facility have the potential to be affected by this finding. The current Food Service Manager (FSM) is maintaining standards of sanitation, food storage and labeling in the kitchen. c) We have made arrangements for the air gaps to be installed at each ice machine. We have cleaned the slats on the hood and created a cleaning schedule to maintain cleanliness of the hood. We have provided education to the kitchen staff regarding the need to properly label food and for the proper use of the 3-bay sink. We have developed a kitchen inspection checklist to monitor kitchen sanitation and food labeling. d) The FSM is responsible for implementing this plan. The kitchen inspection check list will be conducted on a routine basis and the results shared with the QAPI committee monthly. We will review our progress with the QAPI committee for no less than 3 months at which time we will determine the need/frequency to continue formal audits.	4/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 812	Continued From page 48 1. Record review of the Rhode Island Food Code 2018 edition, Section 3-602.11 Food Labels states, "...(B) Label information shall include: (1) The common name of the food..." During the initial tour of the main kitchen on 3/10/2024 at 8:18 AM, in the presence of the Food Service Director (FSD), the following food items were observed with no label: - In the walk-in refrigerator, two bags of hard-boiled eggs were sitting in clear liquid. - In the walk-in freezer, one opened plastic bag of French toast, noted to have white covering the edges, indicating freezer burn. During a surveyor interview, immediately following the above observations, the FSD acknowledged both items and indicated they should be discarded. 2. The Rhode Island Food Code 4.601.11 reads in part,"...the non-food contact surfaces of equipment shall be kept free of an accumulation of...residue..." During the initial tour of the main kitchen on 3/10/2024 at 8:18 AM, in the presence of the FSD, the hood slats were noted to have a heavy accumulation of dust. During a surveyor interview, immediately following the above observation, the FSD acknowledged the heavy accumulation of dust on the hood slats. 3. During a surveyor observation on 3/10/2024 at 8:48 AM of Dietary Aide, Staff Q, he was noted to be washing hotel pans and sheets in the 3 bay	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 812	Continued From page 49 sink. When the surveyor asked Staff Q to use a test strip in the sanitizer sink, he was unable to provide the test strips. He revealed he did not know he needed to use test strips to test the chemicals. During a surveyor interview on 3/10/2024 at 8:55 AM with the FSD she found test strips labeled, "Hydrion QT-40" and tested the chemicals in the sanitizer sink. The test strip did not change color. She revealed that Staff Q added water after dispensing the chemicals. It was later revealed that the test strips she used were not appropriate for the sink and surface cleaner sanitizer chemicals that they were using. During a surveyor interview on 3/15/2024 at 1:35 PM with a representative from Ecolab, he revealed the facility switched chemicals recently. He further revealed they just need to fill the sink with the chemical dispenser, and indicated that it is not recommended for water to be added. 4. The Rhode Island Food Code 2018 Edition 5-202.13 reads in part,"...an airgap between the water supply inlet and the flood level rim of the plumbing fixture equipment...shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch)..." During a surveyor observation on 3/12/2024 at 12:24 PM, of the second-floor ice machine, revealed it did not have an air gap. Additionally, the drain below the air pipe was noted to have a dark substance. During a surveyor observation on 3/12/2024 at 12:26 PM, of the main kitchen's ice machine, revealed it did not have an air gap.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 812	Continued From page 50 During a surveyor interview on 3/12/2024, immediately following the observation of the main kitchen ice machine, with the FSD and Maintenance Director, they acknowledged it did not have an air gap. During a surveyor interview on 3/12/2024 at approximately 2:20 PM with the Maintenance Director, he revealed the ice machine on the second floor is used frequently. He further revealed the ice machine did not have an air gap.	F 812		
F 842 SS=D	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, regardless of the form or storage method of the	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 842	Continued From page 51 records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (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. §483.70(l)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and	F 842	**As a POC for Tag F842:** a) Residents ID#66 and 105 are receiving care according to the plan of care. b) Residents who reside in the facility have the potential to be affected by this finding. We are reviewing documentation to ensure accuracy. c) We have provided education to the nurses regarding the need for accurate documentation. We have stressed the need for them to make frequent rounds to verify that interventions (such as pressure reducing devices, off- loading and leg elevation) are in place, and to make needed corrections if they are not. We have created an audit tool to monitor for compliance. d) The DNS/Designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 3 months; at which time, we will determine the need/frequency to continue formal audits.	4/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 842	Continued From page 52 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. 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 medical records on each resident that are accurately documented for 1 of 1 resident reviewed for heel boots, Resident ID #66 and 1 of 1 resident reviewed for off-loading wounds and elevating legs, Residents ID #105. Findings are as follows: 1. Record review revealed Resident ID #66 was readmitted to the facility in September of 2022 with diagnoses including, but not limited to, stage 4 pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) of the right buttock, fusion of the spine and abnormal posture. Further record review revealed a physician's order dated 10/25/2023 for heel boots to bilateral feet every shift as tolerated for wound care. During surveyor observations on the following date and times there was no evidence of the bilateral heel boots observed: - 3/10/2024 at 9:18 AM - 3/10/2024 at 11:00 AM - 3/10/2024 at 12:05 PM - 3/11/2024 at 8:42 AM - 3/11/2024 at 11:14 AM - 3/11/2024 at 1:00 PM Review of March 2024 Treatment Administration Record (TAR) revealed that the bilateral heel	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 842	Continued From page 53 boots were documented as being in place when they were not;: - 3/10/2024 day shift (7:00 AM to 3:00 PM) - 3/11/2024 day shift (7:00 AM to 3:00 PM) During a surveyor interview on 3/11/2024 at approximately 11:00 AM, with Licensed Practical Nurse, Staff E, she acknowledged that the heel boots were not in place. Additionally, she was unable to locate one of the boots in the resident's room. Further, Staff E was unable to explain why they were signed off as applied when they were not on the resident. 2. Record review revealed Resident ID #105 was readmitted to the facility in December of 2023 with diagnoses including, but not limited to, varicose veins of left lower extremity with ulcer of calf, open wound to left ankle and lower leg, open wound to right lower leg, and lymphedema (swelling). Additional record review revealed a physician's order dated 1/25/2024 to off-load wounds as tolerated. During surveyor observations on the following dates and times there was no evidence of his/her wounds being off-loaded: - 3/10/2024 at 9:17 AM - 3/10/2024 at 11:00 AM - 3/10/2024 at 12:05 PM - 3/11/2024 at 8:30 AM - 3/11/2024 at 11:45 AM - 3/11/2024 at 1:36 PM - 3/11/2024 at 2:24 PM - 3/12/2024 at 9:43 AM	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 842	Continued From page 54 - 3/12/2024 at 11:29 AM - 3/12/2024 at 12:49 PM - 3/12/2024 at 2:37 PM Review of March 2024 TAR revealed that the off-loading of the wounds were documented as being completed on the following dates: - 3/10/2024 day shift (7:00 AM - 3:00 PM) - 3/11/2024 day shift (7:00 AM - 3:00 PM) - 3/12/2024 day shift (7:00 AM - 3:00 PM) During a surveyor interview on 3/12/2024 at approximately 3:00 PM with LPN, Staff F, she was unable to explain why the TAR indicated that the resident's wounds were offloaded when they were not. During a surveyor interview on 3/13/2024 at 2:05 PM with the Director of Nursing Services, she was unable to explain why the staff have been inaccurately documenting in the residents' medical records.	F 842		
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 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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 880	Continued From page 55 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 (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.	F 880	**As a POC for Federal Tag F880:** a) Residents ID#87, 105, 7, 33, 86, and 443 had no ill effects related to these findings. b) Residents who reside in the facility have the potential to be affected by these findings. Our Infection Preventionist is monitoring for the adherence of infection control practices in the facility. c) We have instructed the nurses on the importance of maintaining infection control practices during dressing changes. We have stressed the need for hand hygiene with each glove change during treatments and wound care, as well as education on the potential negative outcomes. We have instructed the nursing staff on the need to perform hand hygiene between residents and to be especially mindful of following posted infection control instructions such as perform hand hygiene before entering and exiting a designated room. Our Infection Preventionist is expected to monitor staff throughout the facility, make needed corrections on the spot and to provide in- service programs as needed to reinforce hand hygiene, glove use and other infection control practices. We have devised an audit tool to monitor for compliance.	4/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 880	Continued From page 56 §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 maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections relative to 2 of 3 residents observed for a wound dressing change, Resident ID #s 87 and 105. Additionally, the facility staff failed to conduct appropriate infection control practices relative to hand hygiene for 4 of 4 residents observed during the medication administration task, Resident ID #s 7, 33, 86, and 443. Findings are as follows: Review of a facility policy titled, "Wounds - Dressing Changes" states in part, "...Procedure for Dressing Change...7. Nurse will remove soiled dressing and dispose of properly...9. Remove the dirty gloves and dispose of properly 10. Hand hygiene will be performed and the nurse will don clean gloves 11. Cleanse the incision [wound]..." 1a) Record review revealed Resident ID #87 was	F 880	d) The DNS/Designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 3 months; at which time, we will determine the need/frequency to continue formal audits.	4/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 880	Continued From page 57 admitted to the facility in December of 2023 with a diagnosis including, but not limited to, chronic venous hypertension with ulcer of lower extremity (wound with delayed healing due to poor circulation). Record review revealed a physician's order dated 1/17/2024 to cleanse with Vashe (wound cleanser) and perform a daily dressing change to his/her left medial calf wound. Additional review of the physician's orders revealed that the resident was on contact precautions (utilizing additional personal protective equipment in addition to standard precautions) due to methicillin-resistant staphylococcus aureus (MRSA, an infection is caused by a type of staph bacteria that's become resistant to many of the antibiotics) in his/her wound. During a surveyor observation on 3/11/2024 at 10:49 AM of the resident's left calf wound dressing change, Registered Nurse (RN), Staff B, was observed to remove the soiled dressing. She proceeded to cleanse the wound using the same gloves she had used to remove the soiled dressing. Staff B failed to remove her dirty gloves, conduct hand hygiene, and don new gloves prior to cleansing the wound as per policy. During a surveyor interview on 3/11/2024 at approximately 11:00 AM with Staff B, she acknowledged that she did not remove her dirty gloves, perform hand hygiene, nor apply clean gloves prior to cleansing the resident's wound. During a surveyor interview on 3/13/2024 at 2:09 PM with the Director of Nursing Services (DNS), she revealed that she would expect the nurse to remove her dirty gloves, perform hand hygiene,	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 880	Continued From page 58 and don new gloves prior to cleansing the resident's wound. 1b) Record review revealed Resident ID #105 was admitted to the facility in May of 2023 with diagnoses including, but not limited to, varicose veins (enlarged veins close to the skin surface) of the left lower extremity with ulcer of calf and open wound to right lower leg. Record review revealed two physician orders dated 1/26/2024 to cleanse with Vashe and perform daily dressing changes to his/her left lower extremity and right posterior calf wounds. During a surveyor observation on 3/13/2024 at 9:21 AM of the resident's left lower calf wound dressing change, Licensed Practical Nurse, Staff F, was conducting the resident's wound dressing change with the assistance of Nursing Assistant, Staff G. The resident's wound was observed to have copious amounts of yellow colored drainage. Staff G was observed to place her gloved hand directly on the resident's exposed wound while lifting the resident's leg. Staff F completed the resident's left lower calf dressing change and proceeded to his/her right posterior calf wound. Staff F, was observed to be using both gloved hands while conducting the resident's right calf wound dressing change. Staff F using the same dirty gloves she had used while performing the dressing change, was then noted to be touching a bottle of Vashe (that is used for multiple residents) to cleanse the resident's wound. Upon completion of the dressing change, Staff F was attempting to return the multi-use Vashe bottle to the treatment cart without first having disinfected the bottle until she was stopped by the surveyor.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 880	Continued From page 59 During a surveyor interview on 3/13/2024 following the above observation with Staff F, she acknowledged that she did not change her dirty gloves after touching the resident's right posterior calf wound and used those same gloves while handling the Vashe bottle. Additionally, she revealed that the Vashe cleanser is used for multiple residents on the unit, including a resident with MRSA in his/her wound. During a surveyor interview on 3/13/2024 at approximately 2:00 PM with the DNS, she revealed that she would expect staff would adhere to proper infection control practices relative to the wound dressing changes and handling of a multi-use wound cleanser. 2. Review of a facility policy titled, "Medication Administration" states in part, "...Medication Administering: Wash hands (or alcohol gel) between each resident...before and after the application of gloves. This applies to all medication administration and treatment procedures..." During a surveyor observation of the medication administration task on 3/11/2024 at 10:15 AM with RN, Staff O, the following observations were made: - 10:15 AM Staff O prepared medication for Resident ID #86. She entered and exited his/her room without performing hand hygiene. She returned to the medication cart and failed to perform hand hygiene. - 10:20 AM Staff O prepared medication for Resident ID #443. She entered and exited his/her	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 880	Continued From page 60 room without performing hand hygiene. Additionally, a sign was posted outside the resident's door that indicated everyone must clean their hands, including before entering and when leaving the room. Staff O then returned to the medication cart and failed to perform hand hygiene. - 10:25 AM Staff O prepared medication for Resident ID #7. She entered and exited his/her room without performing hand hygiene. Additionally, a sign was posted outside the resident's door that indicated everyone must clean their hands, including before entering and when leaving the room. Staff O then returned to the medication cart and failed to perform hand hygiene. - 10:40 AM Staff O prepared medication for Resident ID #33. She donned gloves without first performing hand hygiene. She entered the resident's room, administered an injection, and exited the resident's room without first disposing of the dirty gloves prior to exiting. Additionally, a sign was posted outside the resident's door that indicated everyone must clean their hands, including before entering and when leaving the room. Staff O proceeded down the hallway wearing the dirty gloves until she was stopped by the surveyor. During a surveyor interview on 3/11/2024 at approximately 10:45 AM following the above observations, Staff O acknowledged that she failed to perform hand hygiene throughout the duration of the medication administration task. Additionally, she acknowledged exiting Resident ID #33's room with dirty gloves. She revealed that the dirty gloves should have been disposed of	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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 880	Continued From page 61 prior to exiting the resident's room and that she should have performed hand hygiene between each resident encounter during the medication pass. During a surveyor interview on 3/12/2024 at 3:08 PM with the Infection Preventionist, she revealed that she would expect staff to perform hand hygiene before and after each resident encounter and that the nurse should have discarded her gloves and performed hand hygiene prior to exiting Resident ID #33's room. During a surveyor interview on 3/13/2024 at 10:53 AM with the DNS, she revealed that she would expect staff to follow proper infection control practices. She was unable to explain why the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections.	F 880		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by the Center for Health Facilities and Regulation to determine compliance with 42 CFR §483.73 related to Emergency Preparedness. No deficiency was identified during the survey. Capacity: 185 Census: 141	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cheryl Picard | TITLE: Administrator | (X6) DATE: 4/4/24

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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
K 000	INITIAL COMMENTS The annual Federal Life Safety Code survey was conducted by the State Survey Agency. Trinity Health and Rehabilitation Center was surveyed pursuant to the National Fire Protection Association 101 Life Safety Code, 2012 Edition as referenced in 42 CFR 483.90 (a - d) Physical Environment. Life Safety Code deficiencies were identified during the survey. Capacity: 185 Census: 141	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the	K 222		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cheryl Picard | TITLE: Administrator | (X6) DATE: 4/4/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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
K 222	Continued From page 1 Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by:	K 222	*Life Safety Code (LSC) Tags* **As a POC for Tag K222:** a) There were no residents identified in this citation. b) Although no residents were identified in this tag, we recognize the potential risk to twelve residents and an indeterminable number of staff and visitors related to the means of egress issue noted. c) The facility has made the necessary repairs to the fire rated door on the 3rd floor leading to stair F to ensure that the door locking mechanism opens upon application of continuous force of 30 seconds. We have provided education to the maintenance department on the need to make rounds to check the mechanism and functioning of doors with delayed egress locking system. We have devised a maintenance rounds checklist for this purpose. d) The NHA is responsible for implementing this plan. The rounds/checklist is to be reviewed on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 3 months; at which time, we will determine the need/frequency to continue the formal rounds/checklist.	4/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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
K 222	Continued From page 2 Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to maintain a compliant means of egress with a delayed-egress door-locking system in accordance with National Fire Protection Association (NFPA) 101 2012 Edition. This deficient practice could impact 12 residents in that smoke zone, as well as an indeterminable number of staff and visitors. Findings are as follows: Record review of the NFPA 101 2012 Edition section 7.2.1.6.1.1 states in part, "...An irreversible process shall release the lock in the direction of egress within...30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5 under all of the following conditions: a. The force shall not be required to exceed 15 lbf [pound force]. b. The force shall not be required to be continuously applied for more than 3 seconds. c. The initiation of the release process shall activate an audible signal in the vicinity of the door opening. d. Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only..." During a surveyor observation made in the presence of the Maintenance Director, during the Life Safety Code Tour, on 3/12/2024 at 8:45 AM, the fire-rated door on the 3rd floor leading to exit stair F with an approved delayed-egress door-locking mechanism of 30 seconds failed to	K 222		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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
K 222	Continued From page 3 open upon application of continuous force of more than 30 seconds. During a surveyor interview with the Maintenance Director following the above observation, he acknowledged that the above-mentioned exit access fire-rated door failed to open after 30 seconds of applying continuous pressure.	K 222		4/14/24
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined that the facility failed to maintain the doors with self-closing devices in accordance with the National Fire Protection Association (NFPA) 101 2012 Edition. The deficient practice could impact an indeterminable number of residents, staff, and visitors. Findings are as follows:	K 223	**As a POC for Tag K223:** a) No residents were identified in this citation. b) Although no residents were identified in this tag, we recognize the potential risk to an indeterminable number of residents, staff and visitors associated with the issue noted by the survey team. c) We have made the necessary repairs to ensure that the identified fire doors (3rd floor leading to Exit Stairs E, 2nd floor leading to the Quebec Unit and ground floor leading to Exit Stairs A) close and latch as required. We have provided education to the maintenance department on the importance of making frequent rounds to identify issues related to the closing and latching of fire doors and the need to repair any identified issues in a timely manner. We have devised a maintenance rounds/checklist to monitor for compliance with this. d) The NHA is responsible for implementing this plan. The rounds/checklist is to be reviewed on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 3 months; at which time, we will determine the need/frequency to continue the formal rounds/checklist.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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
K 223	Continued From page 4 During surveyor observations made in the presence of the Maintenance Director on 3/12/2024 during the Life Safety Code Tour, revealed that the following fire-rated doors with self-closing devices failed to fully close and latch as required: - the fire-rated door on the 3rd floor leading to exit stairs E - the fire-rated doors on 2nd floor leading to the Quebec unit - the fire-rated door on ground floor leading to exit stairs A During a surveyor interview with the Maintenance Director following the above observations, he acknowledged that the above-mentioned fire-rated doors failed to fully close and latch as required.	K 223		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain their emergency lighting systems in accordance with National Fire Protection Association (NFPA) 101 2012 Edition and NFPA 110 2010 Edition. This deficient practice could impact 141 of 141 residents, as well as an indeterminable number of staff and visitors.	K 291		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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
K 291	Continued From page 5 Findings are as follows: Review of the NFPA 101 2012 Edition states in part, "...9.1.3.1 Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems [EPS]..." Review of NFPA 110 2010 Edition states in part, "...7.3 Lighting...7.3.1 The Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting..." During a surveyor observation made in the presence of the Maintenance Director, during the Life Safety Code Tour, on 3/12/2024 at 9:30 AM, revealed that the facility failed to install a battery-powered backup emergency lighting unit in the electrical room where the generator transfer switch was located. During a surveyor interview with the Maintenance Director following the above observation, he was unable to provide evidence that the electrical room where the generator transfer switch was located had a battery-powered backup emergency lighting unit as required.	K 291	**As a POC for Tag K291:** a) There were no residents identified in this citation. b) 141 of 141 residents and an indeterminable number of staff and visitors have the potential to be affected by this finding. We have responded accordingly. c) We have installed the necessary battery powered back up emergency lighting unit in the electrical room (where the generator transfer switch is located). We have provided education to the maintenance department regarding the need to monitor and test emergency lighting to ensure that emergency lighting is provided on an automatic basis. We have devised a rounds/checklist to monitor for compliance with this plan. d) The NHA is responsible for implementing this plan. The rounds/checklist is to be reviewed on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 3 months; at which time, we will determine the need/frequency to continue the formal rounds/checklist.	4/14/24
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control	K 324		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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
K 324	Continued From page 6 and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the kitchen hood suppression system was not being maintained in accordance with National Fire Protection Association (NFPA) 101 Life Safety Code 2012 Edition and NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 2011 Edition. This deficient practice has the potential to impact 141 of 141 residents, as well as an indeterminable number of staff and visitors. Findings are as follows:	K 324	**As a POC Tag K324:** a) There were no residents identified in this citation. b) 141 of 141 residents and an indeterminable number of staff and residents have the potential to be affected by this finding. We have responded accordingly. c) We have had the kitchen hood suppression system checked and maintained as necessary. We will begin the required every six month (or as needed) maintenance schedule. The Director of Maintenance has been provided with education on the need to ensure the maintenance is provided as required and that complete and accurate documentation is kept. We have devised a maintenance rounds/checklist to ensure compliance with this plan. d) The NHA is responsible for implementing this plan. The rounds/checklist is to be reviewed on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 3 months; at which time, we will determine the need/frequency to continue the formal rounds/checklist.	4/14/24

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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
K 324	Continued From page 7 Record review of NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 2011 Edition section 11.2 states in part, "...11.2.1* Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person (s) acceptable to the authority having jurisdiction at least every 6 months..." Record review of the facility's kitchen fire suppression system maintenance record on 3/12/2024 revealed that it was last serviced on 1/17/2024. Further record review failed to reveal evidence that it was serviced within six months prior to 1/17/2024 as required. Record review of the facility's kitchen hood cleaning record revealed that it was last serviced on 6/29/2023. Further record review failed to reveal evidence that it was serviced within six months between 6/29/2023 and 3/12/2024 as required. During a surveyor interview with the Maintenance Director in the presence of the Administrator and the Vice President of Operations on 3/12/2024 at 1:50 PM, he was unable to provide evidence that the kitchen suppression system and kitchen hood was serviced by a certified person every six months as required.	K 324		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance	K 345		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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
K 345	Continued From page 8 A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 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 fire alarm system was being maintained in accordance with National Fire Protection Association (NFPA) 101 Life Safety Code 2012 Edition and NFPA 72 National Fire Alarm and Signaling Code 2010 Edition. This deficient practice could impact 141 of 141 residents as well as an indeterminable number of staff and visitors. Findings are as follows: Record review of the NFPA 72 National Fire Alarm and Signaling Code 2010 Edition states in part, "...14.4 Testing. 14.4.5* Testing Frequency. Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction..." Record review of the fire alarm system maintenance reports on 3/12/2024 failed to reveal that the facility maintained the fire alarm system for the three quarters prior to 1/17/2024, when the most recent fire alarm system maintenance was	K 345	**As a POC for Tag K345:** a) There were no residents identified in this citation. b) 141 of 141 residents and an indeterminable number of staff and visitors have the potential to be affected by this finding. We have responded accordingly. c) We have provided education to the Director of the Maintenance regarding the need to ensure that the fire alarm system is inspected and maintained at least quarterly as required. We have stressed the need to maintain accurate and complete records. We have devised a maintenance inspection/checklist to monitor our progress in complying with this plan. d) The NHA is responsible for implementing this plan. The rounds/checklist is to be reviewed on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 3 months; at which time, we will determine the need/frequency to continue the formal rounds/checklist.	4/14/24

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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
K 345	Continued From page 9 performed. During a surveyor interview with the Maintenance Director in the presence of the Administrator and the Vice President of Operations on 3/12/2024 at 1:50 PM, he was unable to provide evidence that the fire alarm system received quarterly maintenance prior to 1/17/2024 as required.	K 345		4/14/24
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 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 automatic sprinkler system was being maintained in accordance with the National Fire Protection Association (NFPA) 101 Life Safety Code 2012 Edition and NFPA 25 Standard for the	K 353	**As a POC for Tag K353:** a) There were no residents identified in this citation. b) 141 of 141 residents and an indeterminate number of staff and visitors had the potential to be affected by this finding. We have responded accordingly. c) The facility has ensured that the current sprinkler system check and maintenance requirements have been met. We have provided education to the Director of Maintenance on the need for compliance every quarter (or as needed), and with complete and accurate documentation that these checks have been made. We have included this requirement on our rounds/checklist sheet to ensure compliance with this plan. d) The NHA is responsible for implementing this plan. The rounds/checklist is to be reviewed on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 3 months; at which time, we will determine the need/frequency to continue the formal rounds/checklist.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HEALTH AND REHABILITATION CENTER	4 ST JOSEPH 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
K 353	Continued From page 10 Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 2011 Edition. This deficient practice has the potential to impact 141 of 141 residents as well as an indeterminable number of staff and visitors. Findings are as follows: Record review of the NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 2011 Edition states in part, "...5.1.1.2 Table 5.1.1.2 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. 5.3.3 Waterflow Alarm Devices. 5.3.3.1 Mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly [every 3 months]..." Record review of the sprinkler system maintenance reports on 3/12/2024 failed to reveal evidence that the facility performed quarterly maintenance of the sprinkler system prior to 1/17/2024, when the most recent sprinkler system maintenance was performed. During a surveyor interview with the Maintenance Director in the presence of the Administrator and the Vice President of Operations on 3/12/2024 at 1:50 PM, he was unable to provide evidence that the sprinkler system received quarterly maintenance prior to 1/17/2024 as required.	K 353		