| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 415023 | A. Building<br>B. Wing | 03/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Sunny View Nursing Home Inc | 83 Corona Street<br>Warwick, RI 02886 |

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| F 0637<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Assess the resident when there is a significant change in condition<br><br>47279<br><br>Based on record review and staff interview, it has been determined that the facility failed to complete a significant change in status assessment within 14 days after there has been a significant change in the resident's physical or mental condition for 4 of 5 sample residents reviewed, Resident ID #s 7, 9, 17, and 30.<br><br>Findings are as follows:<br><br>According to the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual version 3.0, last updated 10/2023 Section A states in part, .If a nursing home resident elects the hospice benefit, the nursing home is required to complete an MDS Significant Change in Status Assessment (SCSA). The nursing home is required to complete an SCSA when the resident comes off the hospice benefit (revoke). See Chapter 2 for details on this requirement. It is a CMS requirement to have an SCSA completed EVERY time the hospice benefit has been elected, even if a recent MDS was done and the only change is the election of the hospice benefit .<br><br>1. Record review revealed Resident ID #7 was admitted to the facility in February of 2023 with a diagnosis including, but not limited to, cerebrovascular disease (a group of disorders that affects the blood vessels and blood supply to the brain).<br><br>Record review revealed Resident ID #7 was admitted to hospice services on 1/1/2024, indicating a significant change in his/her health status.<br><br>Record review failed to reveal evidence that a significant change in status assessment was completed for the resident after being admitted to hospice services.<br><br>2. Record review revealed Resident ID #9 was admitted to the facility in October of 2021 with a diagnosis including, but not limited to, congestive heart failure.<br><br>Record review revealed Resident ID #9 was admitted to hospice services on 2/25/2024, indicating a significant change in his/her health status.<br><br>Record review failed to reveal evidence that a significant change in status assessment was completed for the resident after being admitted to hospice services.<br><br>(continued on next page) |

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.

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

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| F 0637<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | 3. Record review revealed Resident ID #17 was admitted to the facility in January of 2022 with a diagnosis including, but not limited to, dementia.<br><br>Record review revealed Resident ID #17 was admitted to hospice services on 12/23/2023, indicating a significant change in his/her health status.<br><br>Record review failed to reveal evidence that a significant change in status assessment was completed for the resident after being admitted to hospice services.<br><br>4. Record review revealed Resident ID #30 was admitted to the facility in January of 2023 with a diagnosis including, but not limited to, adult failure to thrive.<br><br>Record review revealed Resident ID #30 was admitted to hospice services on 8/6/2023, indicating a significant change in his/her health status.<br><br>Record review failed to reveal evidence that a significant change in status assessment was completed for the resident after being admitted to hospice services.<br><br>During a surveyor interview with the Director of Nursing Services on 3/25/2024 at 11:59 AM, she could not provide evidence that a significant change in status assessment was completed for all four residents mentioned above and stated that she would expect it to be completed within 14 days after their admission to hospice services, as required.<br><br>45855 |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45263<br><br>Based on record review and staff interview if has been determined that the facility failed to provide treatment and care in accordance with professional standards of practice and failed to promptly identify and intervene during an acute change in a resident's condition, related to vomiting and an unknown cardiac event for 1 of 1 resident reviewed, Resident ID #38.<br><br>Findings are as follows:<br><br>Review of a facility policy titled, Resident Change in Condition dated [DATE] states in part, .Changes in condition require assessment by the RN [registered nurse] and notification to the MD [Medical Doctor] (both to be done timely). Timely depends upon the level/severity of the change and RN should use professional assessment and judgement to make that decision. Timely is certainly no later than the shift of the change .<br><br>Record review of a closed record revealed that Resident ID #38, was admitted to the facility in July of 2020 with diagnoses including, but not limited to, vascular dementia and nontraumatic intracerebral hemorrhage (emergency condition in which a blood vessel in the brain ruptures and causes bleeding inside the brain).<br><br>Review of the progress notes revealed the following:<br><br>[DATE] at 9:39 PM - Yelling out for assist. 1 episode of vomiting. Vitals stable, taking fluids well. Rapid covid negative.<br><br>[DATE] at 6:20 AM - Reported from previous shift res [resident] had diarrhea and vomiting previous shift. Res vomited large amount of undigested food x 3. No further diarrhea. Res pale, tired. HOB [head of bed] elevated. Repositioned to side. Call light within reach. Frequent checks<br><br>[DATE] at 8:21 AM - PT [patient] found unresponsive [at] 7:43am, prior to unresponsive pt was alert, talking and able to make needs known, no complaints. unable to find pulse at that time, CPR [cardiopulmonary resuscitation] started and 911 was called at 7:47am. 911 in and CPR continued, pt is being transferred to [hospital] .<br><br>Review of the emergency room documentation dated [DATE] at 8:47 AM revealed that the resident had been transferred to the hospital by Emergency Medical Services (EMS) after being found unresponsive and CPR being administered. Additionally, it revealed that when EMS initially assessed the resident s/he was found to be in ventricular fibrillation (life threatening heart rhythm that results in a rapid, inadequate heartbeat). Further review revealed that due to the resident remaining in persistent asystole (heart stops pumping) in the setting of an unwitnessed cardiac arrest, resuscitation efforts were terminated and the resident was declared dead at 8:36 AM.<br><br>Record review failed to reveal evidence of an assessment completed to include complete vital signs on [DATE] during the 3:00 PM to 11:00 PM shift although the resident had vomited. Further review failed to reveal evidence that a doctor had been notified of the resident's vomiting.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During a surveyor interview on [DATE] at 11:45 AM with the Director of Nursing Services (DNS), she acknowledged that she was the nurse on duty on [DATE] during the 3:00 PM to 11:00 PM shift. Additionally, she revealed that she did obtain the residents vital signs however, she did not document them. The DNS further acknowledged that she did not complete a full assessment and did not report the resident vomiting to the physician.<br><br>Additional record review failed to reveal evidence of an assessment completed to include complete vital signs on [DATE] during the 11:00 PM to 7:00 AM shift although the resident had vomited 3 times and appeared pale and tired. Further review failed to reveal evidence that a doctor had been notified of the residents change in condition.<br><br>During a surveyor interview on [DATE] at 3:10 PM with RN, Staff A, she revealed that she was the nurse on the 11:00 PM to 7:00 AM shift on [DATE]. Additionally, she revealed that the resident was uncomfortable on her shift and was vomiting. Staff A acknowledged that she did not complete a full assessment to include vital signs and she did not report the resident's vomiting to the physician. Furthermore, she revealed that she would have reported abnormal vital signs to the physician but she did not obtain them.<br><br>During a surveyor interview on [DATE] at 12:30 PM with Nurse Practitioner (NP), Staff B, she revealed that she would consider a resident vomiting a change in condition and would expect the staff to notify her of the change. Additionally, she revealed that if she had been aware of the resident vomiting, she would have ordered the staff to perform an assessment to include a complete set of vital signs.<br><br>During a surveyor interview on [DATE] at 9:30 AM with the DNS she was unable to provide evidence that the staff completed an assessment after a change in condition or reported the change in condition to the physician by the end of each shift per the policy.<br><br>The facility's failure to perform an assessment of a resident including vital signs with multiple episodes of vomiting and failure to promptly identify and intervene during an acute change in a resident's condition had the potential to result in the resident's harm or death.<br><br>46715 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>45263<br><br>Based on record review and staff interview, it has been determined that the facility failed to ensure a resident receives care consistent with professional standards of practice to prevent pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable for 1 of 4 residents reviewed, Resident ID #36.<br><br>Findings are as follows:<br><br>Resident ID #36 was admitted to the facility in January of 2024 with a diagnosis that includes, but is not limited to, traumatic hemorrhage of the cerebrum(brain).<br><br>Record review revealed a physician's order for, .encourage/assist to offload heels as tolerated, free float heels with pillow/blanket roll .while bed resting .every shift.<br><br>Record review of a care plan developed on 1/24/2024 revealed in part, .potential for skin breakdown as a result of weakness .<br><br>Further record review of the care plan revealed an approach including, but not limited to, keep bony prominences from direct contact and to offload heels to reduce pressure.<br><br>Surveyor observations on the following dates and times revealed the resident in bed resting and his/her heels resting directly on the mattress, not offloaded:<br><br>-3/20/2024 at approximately 12:25 PM.<br><br>-3/20/2024 at approximately 3:40 PM.<br><br>-3/21/2024 at approximately 10:30 AM.<br><br>-3/21/2024 at approximately 2:00 PM.<br><br>Record review of documents titled 'Wound Evaluation and Management dated 3/5/2024 and 3/12/2024 failed to reveal evidence of any skin impairment to the resident's right heel.<br><br>Record review of a facility document titled Wound Management dated 3/19/2024 revealed a right heel pressure ulcer.<br><br>During a surveyor interview on 3/21/2024 at approximately 2:05 PM with Registered Nurse, Staff C, she acknowledged the resident's heels were not offloaded.<br><br>During a surveyor interview with the Director of Nursing Services on 3/21/2024 at approximately 3:00 PM, she revealed the expectation is for physician orders to be followed. Additionally, she was unable to provide evidence that the facility provided care consistent with professional standards of practice to prevent pressure ulcers. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>45263<br><br>Based on surveyor observation and staff interview, it has been determined that the facility failed to properly store and serve food under sanitary conditions relative to the serving temperatures of a potentially hazardous food item and improper cooling procedures.<br><br>Findings are as follows:<br><br>1. Record review of The State of Rhode Island Food Code 2018 Edition 3-501.6 states in part, .Except during preparation, cooking or cooling .time/temperature control for safety, food shall be maintained at 5 degrees C [Celsius] 41 degrees F [Fahrenheit] or less .<br><br>During a surveyor observation of the lunch meal in the dining room on 3/22/2024 at approximately 12:13 PM 19 souffle cups of tartar sauce were sitting at ambient temperature. The temperature reading was 62 degrees F.<br><br>Following the above observation, a temperature recording of the tartar sauce served from the main kitchen had a temperature reading of 50 degrees F.<br><br>During a surveyor interview on 3/22/2024 at approximately 12:25 PM, with the Food Service Director, he acknowledged the tartar sauce was not at the acceptable cold holding temperature of 41 degrees F or lower.<br><br>2. Record review of The Rhode Island Food Code 2018 Edition 3-501.14 reads in part, .cooked/time temperature control for food safety shall be cooled .within 2 hours from 135 degrees Farenheit to 70 degrees F .<br><br>During a surveyor observation on 3/20/2024 at approximately 9:30 AM of a refrigerator unit, a cooked roast beef with a date of 3/19/2024 was identified.<br><br>Record review of a facility document titled Cooling Food Temperature Log revealed the following items that did not reach the desired temperature of 70 degrees F within 2 hours as part of the active cooling process:<br><br>- 2/26/2024 Meatloaf: 2 hour temperature time was 80 degrees F.<br><br>- 3/13/2024 Turkey: 2 hour temperature time was 85 degrees F.<br><br>- 3/19/2024 Roast Beef: 2 hour temperature time was 90 degrees F.<br><br>Record review failed to reveal evidence that the above-mentioned foods were cooled to 70 degrees F within 2 hours per the food code.<br><br>During a surveyor interview with the Food Service Director on 3/20/2024 at approximately 10:00 AM, he acknowledged the 3 mentioned items did not meet 70 degrees within 2 hours per the Food Code. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>47279<br><br>Based on record review, surveyor observation, 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 a potential gastrointestinal (GI) virus outbreak on 2 of 2 nursing units affecting Resident ID #s 23, 32, 33, and 38. Additionally, the facility staff failed to conduct appropriate infection control practices relative to wound dressing changes for 1 of 2 residents with observed dressing changes, Resident ID #22.<br><br>Findings are as follows:<br><br>Review of a facility policy titled, Surveillance Guidelines last revised 1/2018 states in part, .POLICY: It is the policy of this facility to carry out routine, regular surveillance throughout the facility .Outcome Surveillance- a process designed to identify and report evidence of infection. The process involves the collection/documenting of data on individual cases and comparing the collected data to standard written definitions of infections for the purpose of identifying the prevalence of infections at any given time or to help identify new cases. When a resident exhibits signs and symptoms of an infection the charge nurse will:<br><br>- Record the resident's name, room number, symptoms, and diagnostic tests done, as well as the results of the tests, using the facility inter-shift communication process.<br><br>- Residents who are being treated for infections are also to be reported together with presence or absence of symptoms until 48 hours after the last dose of antibiotic.<br><br>- Follow routine procedures for notifying the physician and family and begin close monitoring of vital signs and intake and output.<br><br>- Document in the nurses progress notes, the presence or absence of symptoms.<br><br>The Infection Preventionist (IP) will begin gathering data for the formal surveillance process by:<br><br>- Reviewing the information provided by the facility inter-shift communication process.<br><br>- Utilization of a standardized surveillance tool .<br><br>- Starting a line listing of potential nosocomial infections [infections acquired in a hospital or other healthcare facility].<br><br>- Reviewing the medical records as necessary to accurately identify infections.<br><br>- Analyzing the results of the review.<br><br>- Provide a monthly report of the analysis.<br><br>- Document corrective actions for incidents identified .<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a surveyor interview on 3/21/2024 at 3:10 PM with Registered Nurse, Staff A, she revealed that in February of 2024, there were quite a few residents with one or two episodes of vomiting, approximately five or six residents with the stomach bug.<br><br>1a) Record review revealed that Resident ID #38 was admitted to the facility in July of 2020 with a diagnosis including, but not limited to, vascular dementia. Additionally, s/he resided on the South Wing.<br><br>Review of the following progress notes revealed s/he was exhibiting signs and symptoms of a potential GI illness:<br><br>- 2/9/2024 at 9:39 PM .1 episode of vomiting .<br><br>- 2/10/2024 at 6:20 AM .had diarrhea and vomiting previous shift .vomited large amount of undigested food x 3 .<br><br>Cross Reference F684.<br><br>1b) Record review revealed that Resident ID #33 was readmitted to the facility in May of 2023 with a diagnosis including, but not limited to, heart failure. Additionally, s/he resided on the South Wing.<br><br>Review of the following progress notes revealed s/he was exhibiting signs and symptoms of a potential GI illness:<br><br>- 2/8/2024 at 6:27 AM .vomited a large amount of undigested food x 1 about 1:30 AM .<br><br>1c) Record review revealed that Resident ID #23 was admitted to the facility in January of 2024 with a diagnosis including, but not limited to, adult failure to thrive. Additionally, s/he resided on the South Wing.<br><br>Review of the following progress notes revealed s/he was exhibiting signs and symptoms of a potential GI illness:<br><br>- 2/11/2024 at 6:42 PM .Had period of nausea .<br><br>- 2/15/2024 at 9:24 AM .NP [Nurse Practitioner] in to visit c/o [complains of] nausea .<br><br>- 2/15/2024 at 3:39 PM .[medication] given .for nausea .<br><br>1d) Record review revealed that Resident ID #32 was readmitted to the facility in February of 2024 with a diagnosis including, but not limited to, bacteremia (bacteria in the blood). Additionally, s/he resided on the North Wing.<br><br>Review of the following progress notes revealed s/he was exhibiting signs and symptoms of a potential GI illness:<br><br>- 2/13/2024 at 5:15 PM .reporting nausea .<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review failed to reveal evidence that a line list was initiated as per policy after the above-mentioned residents exhibited signs and symptoms of a GI illness between 2/8-2/15/2024.<br><br>During a surveyor interview on 3/22/2024 at approximately 10:30 AM with the Regional IP during the infection control task, she acknowledged that the facility's outbreak protocol for a GI illness is initiated when 2 or more residents are exhibiting signs and symptoms. She further revealed that a line list of residents would be initiated for appropriate surveillance. Additionally, she revealed a line list was not completed and that she would expect one to be completed.<br><br>During a surveyor interview on 3/22/2024 at 10:54 AM with the Director of Nursing Services (DNS), she acknowledged that the facility did not create a line list for residents that experienced signs and symptoms of a GI illness in February of 2024. She was unable to provide evidence that the facility maintained an infection prevention and control program to help prevent the transmission of communicable diseases and infections relative to a potential gastrointestinal virus outbreak.<br><br>2. Review of a facility policy titled, Clean Dressing Technique states in part, .It is the policy of this facility to prevent the spread of infection by utilizing proper dressing change technique .12. Remove old dressing .13. Remove gloves. Wash Hands. (Hand sanitizer may be used) Apply clean gloves .<br><br>Record review revealed Resident ID #22 was admitted to the facility in May of 2022 with a diagnosis including, but not limited to, dementia.<br><br>Record review revealed a physician's order dated 3/20/2024 for Santyl (wound ointment) with special instructions to cleanse the left heel and perform a daily dressing change.<br><br>During a surveyor observation on 3/20/2024 at 1:09 PM of the resident's left heel wound dressing change, Licensed Practical Nurse, Staff D, was observed to remove the soiled dressing. She proceeded to cleanse the wound and apply a clean dressing using the same gloves she had used to remove the soiled dressing. Staff D failed to remove her dirty gloves, conduct hand hygiene, and don new gloves prior to applying the clean dressing as per policy. Additionally, during the wound dressing change, Staff D touched the resident's wound care supply bag to retrieve an item with her dirty gloves and later returned the bag to a main supply closet containing clean items.<br><br>During a surveyor interview on 3/20/2024 at approximately 1:20 PM with Staff D, she acknowledged that she did not remove her dirty gloves, perform hand hygiene, nor apply clean gloves prior to applying the clean dressing. Additionally, she acknowledged touching the resident's wound supply bag with her dirty gloves during the dressing change and later returning it to a clean supply closet. She revealed that she should have removed her dirty gloves, performed hand hygiene, and applied clean gloves prior to applying the clean dressing and should not have touched the wound supply bag with her dirty gloves.<br><br>During a surveyor interview on 3/21/2024 at 2:38 PM with the DNS, she revealed that she would expect the nurse to follow proper infection control practices. Additionally, she was unable to provide evidence that the facility maintained an infection prevention and control program to help prevent the transmission of communicable diseases and infections relative to a wound dressing change. |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47279<br><br>Based on surveyor observations, record review, and staff interview, it has been determined that the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for 1 of 1 resident reviewed for an adaptive call pad, Resident ID #34.<br><br>Findings are as follows:<br><br>According to, State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities last revised 2/3/2023, revealed in part that the facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside. Guidance dictates that the call system must be accessible to residents while in their bed or other sleeping accommodations within the resident's room.<br><br>Record review revealed the resident was admitted to the facility in May of 2022 with a diagnosis including, but not limited to, cerebrovascular disease (a group of disorders that affects the blood vessels and blood supply to the brain).<br><br>Review of a Minimum Data Set assessment dated [DATE] revealed that the resident has an upper extremity impairment on one side.<br><br>Surveyor observations on the following dates and times revealed that the resident's adaptive call pad was noted near the upper right of the mattress and not within the resident's reach:<br><br>-3/20/2024 at 9:33 AM.<br><br>-3/22/2024 at 12:20 PM, 1:45 PM, and approximately 4:25 PM.<br><br>-3/25/2024 at 9:20 AM.<br><br>During a surveyor observation and simultaneous interview on 3/25/2024 at 9:20 AM with Licensed Practical Nurse, Staff D, she acknowledged that the resident's adaptive call pad was out of his/her reach. She revealed that the adaptive call pad should be placed near his/her hands because s/he has contractures (permanent tightening of the muscles and tendons). Additionally, Staff D placed the adaptive call pad near the resident's hands, and the resident demonstrated s/he was able to trigger the call light once it was within his/her reach.<br><br>During a surveyor interview on 3/25/2024 at 9:25 AM with the Director of Nursing Services, she revealed that her expectation would be that the resident's adaptive call pad is placed within the resident's reach. |