STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415028	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Shore Health Center	109 West Shore Road Warwick, RI 02889

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 46715 Based on record review and staff interview it has been determined that the facility failed to keep residents free from significant medication errors for 2 of 2 residents reviewed relative to antibiotic use, Resident ID #s 16 and 102. Findings are as follows: 1. Record review revealed that Resident ID #16 was admitted to the facility in April of 2023 with diagnoses including, but not limited to, chronic respiratory failure and chronic obstructive pulmonary disorder. Review of an X-ray report dated 5/28/2024 revealed that the resident has a right lower lobe infiltrate (an abnormality in the lung). Review of a progress note dated 5/28/2024 revealed a new order for Augmentin (an antibiotic) twice a day for 7 days. Review of the May 2024 Medication Administration Record (MAR) revealed that the resident received 6 days of Augmentin and not 7 days as ordered. This indicates that the resident received two less doses than what was ordered. 2. Record review revealed that Resident ID #102 was readmitted to the facility in May of 2024 with diagnoses including, but not limited to, methicillin resistant staphylococcus aureus infection and sepsis (an infection of the blood stream). Review of the hospital Continuity of Care form dated 5/27/2024 revealed an order for intravenous Cefepime (antibiotic) every 12 hours for 10 days. Review of the May 2024 MAR revealed the resident received 19 doses of Cefepime versus the 10 days or 20 doses as ordered. This indicates that the resident received one less dose than what was ordered. During a surveyor interview on 6/7/2024 at 8:13 AM with the Director of Nursing Services she acknowledged that Resident ID #s 16 and 102 did not receive their antibiotics as ordered. Additionally, she was unable to provide evidence that the above residents were kept free from significant medication errors.

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 45263 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to assure that residents receive and consume beverages and food in the appropriate form for 1 of 2 residents reviewed for thickened beverages, Resident ID #25 and for 3 of 5 residents reviewed for mechanical soft diets, Resident ID #s 8, 25 and 62. Findings are as follows: 1. Record review revealed Resident ID #25 was admitted to the facility in May of 2023 with a diagnosis that includes, but is not limited to, dysphagia (difficulty swallowing). Record review of a physician order for the month of June 2024 revealed in part, .House, HONEY THICK, [consistency of bees honey] Mechanical Soft with Puree Fruit and veg . Record review of a Speech Language Pathologist (SLP) Evaluation and Plan of Treatment dated 6/6/2024 at 10:46 AM revealed in part, .resident demonstrated with moderate to severe oropharyngeal dysphagia. coughing during and after swallow .NECTAR [liquid that is the comparable to the consistency of apricot nectar] severe oral impairments characterized by an incomplete bolus [ball like mixture of food and saliva that forms in the mouth] formation and premature spillage into the pharynx[throat] .HONEY liquid .incomplete bolus formation and suspected spillage into pharynx. Reflexive throat clearing during intake complete bolus formation, coughing after swallow . 1a. During a surveyor observation of the lunch meal on 6/4/2024 revealed that the resident received 4 ounces of pre-thickened nectar apple juice. 1b. An additional surveyor observation on 6/4/2024 at approximately 2:30 PM revealed the hospice nursing assistant (NA) preparing the honey thickened beverage for the resident using a nectar thick gel packet. The hospice NA mixed two packets of nectar gel thickener with 7.5 ounces of a cola beverage. This indicates that the liquid was not thickened to the ordered honey thick consistency. During a surveyor interview directly following the above observation with the hospice NA she acknowledged that she mixed two packets of nectar thickener into the beverage and revealed it was too thin. She then mixed a third packet into the soda and proceeded to assist the resident with drinking it. During a surveyor interview with the SLP on 6/5/2024 at approximately 2:30 PM she revealed it would take 4 packets of nectar gel thickener mixed in 7.5 ounces of fluid to achieve the appropriate honey thick consistency. 1c. During surveyor observation during the lunch meal on 6/6/2024 the resident received pre-thickened nectar thick water and cranberry juice. During a surveyor interview on 6/6/2024 at approximately 12:05 PM with Licensed Practical Nurse, Staff B, she acknowledged the beverages were not honey thick as ordered. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of the facility's diet manual titled Dietitians of New England states in part, .Soft/Bite Size Consistency, Foods to avoid .Protein foods in sizes larger than 1.5cm (centimeters) x 1.5 cm pieces .fish that is not soft enough to be cut in 1.5 cm x 1.5 cm pieces .any raw vegetables . During a surveyor interview on 6/5/2024 at approximately 2:30 PM with the SLP she revealed the soft/bite size consistency diet descriptor from the diet manual is what the facility utilizes for the physician diet orders for mechanical soft diets. Record review of the facility menu titled [NAME] Shore Health Center Week 3 S/S[Spring/Summer] reads in part . Mech Soft Texture Diets: Tuesday: Spaghetti and Meatballs Tossed Salad Thursday: Meatloaf, moist ground w/gravy Friday Beer Battered Cod Coleslaw 2a. Record review of Resident ID #8 revealed that s/he was admitted to the facility in March of 2024 with a diagnosis including, but not limited to, dysphagia (difficulty swallowing). Record review revealed Resident ID #8 had a physician's order dated 5/20/2024 for House, Mechanical Soft . Record review of his/her care plan, revised on 3/8/2024, revealed in part, .Diet: reg, mech, [mech soft] During a surveyor observation on 6/6/2024 at 12:00 PM, of the resident's lunch meal revealed that s/he received a slice of meatloaf that was not cut up into the appropriate sized pieces according to the diet manual. During a a surveyor interview with the SLP on 6/6/2024 at 12:12 PM, she acknowledged that the resident's meal was not cut into small enough pieces for the resident to safely swallow. Additionally, she indicated she would expect meals to be served per the physician order as well as the diet descriptor listed in the facility's diet manual. 2b. Record review revealed Resident ID #25 was admitted to the facility in May of 2023 with a diagnosis including, but not limited to dysphagia. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a physician order for the month of June revealed in part, .House, HONEY THICK, Mechanical Soft with Puree Fruit and veg . During a surveyor observation of the lunch meal on 6/4/2024 the resident received whole meatballs that were cut in quarters, not cut up into the appropriate sized pieces according to the diet manual. Further surveyor observations of the lunch meal on 6/6/2024 and 6/7/2024 revealed a slice of meatloaf, not cut up into the appropriate sized pieces according to the diet manual and battered fish that was not cut up into the appropriate sized pieces according to the diet manual. During a surveyor interview on 6/7/2024 at approximately 12:05 PM with Licensed Practical Nurse, Staff B, she was unable to provide evidence that the diet was served per the descriptor in the diet manual. 2c. Record review for Resident ID #62 revealed that s/he was admitted to the facility in December of 2018, with a diagnosis including but not limited to dysphagia. Record review revealed Resident ID #62 had a physician's order dated 4/12/2024 for House, Mechanical Soft Special Instructions: no corn no rice no raw salads no straws Fortified potatoes with dinner and fortified pudding with lunch. During a surveyor observation of lunch meal service on 6/07/2024 at 11:47 AM, revealed that the resident was served a piece of uncut battered fish with steak fried potatoes. During an interview with the SLP on 6/07/2024 at 11:52 AM, she revealed it was her expectation that the fish and potatoes would be cut up into small bite size pieces as indicated by the description outlined in the facility's diet manual. During a surveyor interview on 6/6/2024 at approximately 2:00 PM with the Food Service Director he was unable to provide evidence that the mechanical soft diets were served per the descriptor that was outlined in the facility's diet manual. During a surveyor interview on 6/7/2024 at approximately 1:40 PM with the Administrator and the Director of Nursing Services they were unable to provide evidence that the mechanical soft diets and thickened liquids were served in their appropriate food form.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 47279 Based on record review and staff interview, it has been determined that the facility failed to provide a safe and sanitary environment to help prevent the transmission of infections relative to implementing a water management program based upon industry standards and/or the Centers for Disease Control and Prevention (CDC) toolkit. Findings are as follows: Review of the CDC document titled, Developing a Water Management Program to Reduce Legionella [a bacteria that may cause a very serious type of lung infection] Growth & Spread in Buildings, dated June of 2021, Version 1.1 states in part, .The key to preventing Legionnaires' disease is maintenance of the water systems in which Legionella may grow .Water stagnation: Encourages biofilm growth and reduces temperature and levels of disinfectant. Common issues that contribute to water stagnation include .reduced building occupancy .Stagnation can also occur when fixtures go unused, like a rarely used shower . Review of a document titled, Risk management plan for LEGIONELLA CONTROL last revised on 2/19/2024, revealed in part that the facility provides water to 145 residents for purposes including, but not limited to, drinking, bathing, toilet flushing, laundry services, food preparation, and ice making. Review of a document titled, [NAME] Shore Health Center Water Management Program Hazard identification and risk assessment table revealed that the pipework risk score was considered high due to low flow in several areas. This may allow the growth and spread of Legionella as there is no control measure in place for weekly flushing of areas of low water use. Record review revealed that the facility census on 6/4/2024 was 134 residents. Additional record review failed to reveal evidence that the facility had identified areas of low water use, such as, unoccupied rooms and infrequently used water fixtures. Further record review failed to reveal that the facility implemented their control measure of weekly flushing to mitigate the risk for the growth and spread of Legionella. During a surveyor interview on 6/7/2024 at 11:18 AM with the Maintenance Director he was unable to provide evidence that the facility is following the risk management plan for Legionella including monitoring and flushing infrequently used water fixtures that includes, but is not limited to, toilets and faucets in unoccupied resident rooms. During a surveyor interview on 6/7/2024 at 11:30 AM with the Director of Nursing Services and the Administrator, they were unable to provide evidence that they maintained or implemented a water management program based upon industry standards and the CDC toolkit for the prevention of Legionella, as required.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 46715 Based on record review and staff interview, it has been determined that the facility failed to establish an Infection Prevention and Control Program (IPCP) that must include, at a minimum, an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use for 1 of 2 residents reviewed on antibiotics, Resident ID #16. Findings are as follows: According to the Centers for Disease Control and Prevention document titled, The Core Elements of Antibiotic Stewardship for Nursing Homes states in part, Standardize the practices which should be applied during the care of any resident suspected of an infection or started on an antibiotic. These practices include improving the evaluation and communication of clinical signs and symptoms when a resident is first suspected of having an infection, optimizing the use of diagnostic testing, and implementing an antibiotic review process, also known as an antibiotic time-out, for all antibiotics prescribed in your facility. Antibiotic reviews provide clinicians with an opportunity to reassess the ongoing need for and choice of an antibiotic when the clinical picture is clearer and more information is available .Track the amount of antibiotic used in your nursing home to review patterns of use and determine the impact of new stewardship interventions . Interventions designed to shorten the duration of antibiotic courses, or discontinue antibiotics based on post-prescription review (i.e., antibiotic time-out), may not necessarily change the rate of antibiotic starts, but would decrease the antibiotic DOT [days of therapy] . Record review revealed that the resident was admitted to the facility in April of 2023 with diagnoses including, but not limited to, chronic respiratory failure and chronic obstructive pulmonary disorder. Review of an X-ray report dated 5/28/2024 revealed that the resident has a right lower lobe infiltrate (an abnormality in the lung). Review of a progress note dated 5/28/2024 revealed a new order for Augmentin (an antibiotic) twice a day for 7 days. Review of the May 2024 Medication Administration Record (MAR) revealed an order dated 6/1/2024 for, Complete Appropriateness of Antibiotic Assessment Observation related to recent start of antibiotic therapy Record review failed to reveal evidence of an Appropriateness of Antibiotic Assessment Observation completed for the resident. During a surveyor interview on 6/7/2024 at 8:13 AM with the Director of Nursing Services she acknowledged that an Appropriateness of Antibiotic Assessment Observation was not completed as ordered. Additionally, she was unable to provide evidence that the antibiotic review process, also known as an antibiotic time-out as part of the antibiotic stewardship program was completed.