STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415044	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendly Home Inc The	303 Rhodes Avenue Woonsocket, RI 02895

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 47939 50004 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice relative to following physician's orders for 1 of 2 residents reviewed for offloading heels to prevent pressure injury, Resident ID #73, and for 1 of 1 resident reviewed for glucose monitoring with parameters, Resident ID #85. Findings are as follows: According to Mosby's 4th Edition, Fundamentals of Nursing page 314, which states in part, 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 #73 was readmitted to the facility in July of 2024 with diagnoses including, but not limited to, adult failure to thrive and malnutrition. Record review revealed a physician's order dated 7/26/2024 to offload bilateral heels while in bed. Surveyor observations on the following dates and times revealed the resident heels were not offloaded and his/her heels were resting directly on the mattress: -9/30/2024 at 9:40 AM -9/30/2024 at 11:17 AM -10/1/2024 at 3:30 PM -10/2/2024 at 9:25 AM -10/3/2024 at 9:19 AM (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/04/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 10/3/2024 at 9:02 AM with Registered Nurse, Staff B, she acknowledged that the resident's heels were not offloaded and was unable to explain why his/her heels were not offloaded per the physician's order. During a surveyor interview on 10/3/2024 at 10:37 AM with the Director of Nursing Services (DNS), he was unable to explain why the above-mentioned physician order was not followed. 2. Record review revealed Resident ID #85 was admitted to the facility in September of 2024 with a diagnosis including, but not limited to, diabetes. Record review revealed a physician's order dated 9/10/2024 for blood sugar checks twice a day, and to call the provider if the blood sugar is less than 50 milligrams per deciliter (mg/dl) or greater than 250 mg/dl. Record review of the September 2024 Treatment Administration Record revealed the following blood sugar levels: -9/10/2024: 286 mg/dl -9/11/2024: 273 mg/dl -9/12/2024: 268 mg/dl -9/15/2024: 290 mg/dl -9/16/2024: 281 mg/dl -9/18/2024: 291 mg/dl -9/21/2024: 254 mg/dl -9/23/2024: 336 mg/dl -9/24/2024: 276 mg/dl -9/27/2024: 306 mg/dl -9/28/2024: 346 mg/dl -9/30/2024: 254 mg/dl Record review failed to reveal evidence that the above blood sugar levels greater than 250 mg/dl were reported to the provider as ordered. During a surveyor interview on 10/3/2024 at 11:03 AM with the DNS, he acknowledged that the above-mentioned blood sugars were not reported to the physician. Additionally, he revealed that he would have expected the staff to follow the physician's order.

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NAME OF PROVIDER OR SUPPLIER Friendly Home Inc The		STREET ADDRESS, CITY, STATE, ZIP CODE 303 Rhodes Avenue Woonsocket, RI 02895	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21613 Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice relative to following physician's orders for wound care for 1 of 1 resident reviewed relative to non-pressure injuries, Resident ID #273, for 1 of 1 resident reviewed relative to lower extremity edema (swelling due to an excess fluid in the body tissues), Resident ID #64 and 1 of 2 residents reviewed with a skin tear, Resident ID #90. Findings are as follows: 1. Record review revealed that Resident ID #273 was readmitted to the facility on [DATE] with diagnoses including, but not limited to, abscess of the right foot, cellulitis (bacterial skin infection) of the right toe, ulcer to the right foot, and diabetes mellitus. a. Record review revealed a physician's order dated 9/25/2024 for an admission body audit to be completed. Record review of the September 2024 Treatment Administration Record (TAR) revealed that Registered Nurse, Staff C signed off that she completed the admission body audit on 9/25/2024. Further record review failed to reveal evidence that the admission body audit was completed. b. Record review revealed a physician's order dated 9/26/2024 for a weekly body audit to be completed on Mondays on the 3:00 PM to 11:00 PM shift. Record review of the September 2024 TAR revealed that Staff C signed off that she completed the weekly body audit on 9/30/2024. Further record review failed to reveal evidence that the weekly body audit that was signed off as completed on 9/30/2024 by Staff C, was conducted. c. Record review revealed the following physician's orders dated 9/26/2024: - cleanse large open blister to right foot and great toe with normal saline, apply xeroform (petroleum gauze), fluff gauze and wrap with cling three times per week. - cleanse right heel with saline, skin prep (a liquid that when applied to the skin forms a protective film or barrier) the peri wound (is the skin around the wound that has been affected by the wound), cut and apply black foam to fit the wound bed and cover with wound vac dressing (Wound VAC, is a technique that uses negative pressure to pull the edges of a wound together and promote healing) Record review of the September 2024 TAR revealed, the dressing to the large open blister to the right foot, right toe and the wound VAC dressing to the right heel were signed off as completed by Staff C on 9/28/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 10/2/2024 at 11:18 AM, with Staff C, she acknowledged that, although she signed off that she completed the admission body audit, the weekly body audit, and the wound care treatments to the large open blister to the right foot, right toe and the wound VAC dressing to the great heel on 9/28/2024, she had not. When asked why she signed off on the above-mentioned orders and did not complete them she could not answer. Further, she stated that she was not aware of how many wounds the resident had because she had not completed any assessments or treatments to the resident wounds to his/her right foot, right toe, and right heel. This indicates that the resident did not have his/her wound dressings changed from 9/26/2024 until 10/1/2024. 2. Record review revealed a physician's order dated 9/26/2024 to cleanse the right heel with saline, skin prep to the peri wound, cut and apply black foam to fit the wound bed and cover with wound vac dressing. Record review revealed that the wound vac that was in use for this resident was the Genadyne XLR8. Record review of the Genadyne XLR8 user guide states in part .multiple layers of the transparent film dressing may decrease the moisture vapor transmission rate, which may increase the risk of maceration [a softening and breaking down of skin resulting from prolonged exposure to moisture] .do not allow wound filter to overlap onto intact skin . On 10/1/2024 at approximately 2:00 PM, Staff Development Coordinator (SDC) was observed conducting the removal of the resident's wound vac dressing. The old wound vac dressing was noted to have multiple layers of the transparent film dressing covering both the right foot and right heel although the wound vac order was only to apply the wound vac to the right heel. The disposable backing of the transparent film dressing was not removed prior to the application to the wound. The large blister to the right foot wound was observed to be dressed with an allevyn dressing (a foam dressing) applied under the layer of the wound vac dressing. The order indicated to use xeroform and gauze which were not applied. Additionally, the dressing to the right foot wound should not have been applied under the wound vac dressing. The surveyor observed his/her right foot to be white in color and macerated. During a continued surveyor observation of the reapplication of the wound vac dressing with the SDC, she failed to apply the skin prep to the peri wound of the resident's right heel and failed to apply the xeroform to the resident's great toe as ordered. During a surveyor interview with the SDC immediately following the above observation, she acknowledged that the disposable backing of the transparent film dressing was not removed and the wound vac dressing was applied to both the resident's right heel and foot and should only have been applied to the right heel. She acknowledged that, upon removal of the dressing there was an allevyn in place when the order was for xeroform. Furthermore, she acknowledged that she did not apply skin prep to the right heel peri wound or apply the xeroform to the resident's right great toe as ordered. During a surveyor interview on 10/2/2024 at 12:56 PM and 1:25 PM with the Director of Nursing Services (DNS) he was unable to provide evidence that the skin assessments were completed as ordered. Additionally, he indicated it would be his expectation for wound care treatments to be completed as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review revealed Resident ID #64 was admitted to the facility in April of 2023 with a diagnosis including, but not limited to, hypertension (high blood pressure). Record review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 indicating the resident has mild cognitive impairment. Surveyor observations on the following dates and times, revealed the resident with approximately 1 plus (mild) edema on both of his/her lower legs and ankles: -9/30/2024 at 1:57 PM -10/1/2024 at approximately 2:00 PM -10/2/2024 at 11:03 AM During a surveyor interview with the resident on 10/2/2024 at 11:56 AM, the resident revealed his/her legs have been swollen. During a surveyor interview on 10/2/2024 at 1:25 PM with Licensed Practical Nurse, Staff D, she revealed she was unaware of the edema on the resident's lower legs and ankles. Staff D further stated that there was no documentation and/or interventions in the resident's record relative to the edema and she was unable to provide evidence that the provider had been notified. During an additional surveyor observation of the resident on 10/2/2024 at 1:29 PM with Staff D, she acknowledged the resident's lower legs and ankles were observed with 1 plus edema. Record review revealed the following physician's orders were obtained by Staff D, after the edema was brought to her attention by the surveyor: -Discontinue Lasix (a medication prescribed to treat extra fluid in the body (edema) -Start Torsemide (a medication prescribed to to reduce extra fluid in the body) -Obtain weekly weight x 4 weeks -Discontinue Lisinopril (a medication prescribed to treat high blood pressure) -Obtain blood work including but not limited to a basic metabolic panel (a blood test that provides information about body's fluid balance, metabolism and how well the kidneys are working) During a surveyor interview on 10/2/2024 at 1:37 PM with the DNS, he revealed it would be his expectation that staff would notify the resident's provider relative to the bilateral lower extremity edema. 4. Record review revealed Resident ID #90 was admitted to the facility in July of 2023 with diagnoses including, but not limited to, cognitive deficit and neuropathy (nerve damage that causes weakness, numbness and pain in the hands and feet). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Quarterly MDS assessment dated [DATE] revealed a BIMS score of 7 out of 15 indicating the resident has severe cognitive impairment. Record review revealed a care plan dated 7/1/2024 with a focus care area for potential for alteration in skin integrity with interventions including, but not limited to, monitor skin integrity every shift as needed with prompt treatment to any red or open areas that develop. Surveyor observations on the following dates and times revealed the resident with a bandage (approximately 3 inches in length by 1.5 inches in width) dated 9/30/2024 on his/her left shin: -9/30/2024 at approximately 11:00 AM -10/1/2024 at 8:52 AM -10/2/24 at 10:43 AM During a surveyor interview on 10/2/2024 at 11:06 AM with the resident, s/he revealed s/he has open areas on his/her left lower leg and that the bandage was placed two days ago. During a surveyor interview on 10/2/2024 at 11:14 AM with Staff D, she stated that she did not place the bandage on the resident's left shin. Staff D further revealed that there was no documentation or orders in the resident's record as to why the resident has the bandage on his/her left shin. Staff D further stated that the record lacked evidence that the resident's provider had been notified relative to the open area. During a surveyor observation of the resident with Staff D, on 10/2/2024 at 11:20 AM, she acknowledged the resident had a bandage with the date of 9/30/2024. After Staff D removed the bandage from the resident's left shin, in the presence of the surveyor, s/he was observed with the following: - a scab, approximately 1.25 centimeter (cm) in length by 0.5 cm in width - a skin tear, approximately 0.75 cm in length by 2 cm in width The surveyor also observed the skin tear appeared to be wet/soggy with a small amount of light tan colored drainage. Record review revealed the following physician's orders were obtained for the left shin skin tear after it was brought to the facility's attention by the surveyor: - Apply skin prep (a liquid that when applied to the skin forms a protective film or barrier) to the scab twice daily -Cleanse the skin tear with normal saline, follow by Bacitracin and apply dry clean dressing. During a surveyor interview on 10/2/2024 at 1:40 PM with the DNS, he was unable to provide evidence that the resident's provider was notified, and a treatment order was obtained relative to the open area on the left shin prior to being brought to the facility's attention by the surveyor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	47939

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47939 50004 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that residents with pressure ulcers receive the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 2 of 6 residents reviewed for pressure ulcers, Resident ID #s 35 and 103. Findings are as follows: 1. Record review revealed that Resident ID #35 was readmitted to the facility in August of 2024 with a diagnosis including, but not limited to, unstageable pressure ulcer (characterized by full-thickness skin and muscle loss, with dead tissue obstructing the wound bed) to the right heel. Record review of the Quarterly Minimum Data Set Assessment (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 7 out of 15, indicating the resident has severe cognitive impairment. Record review revealed a physician's order dated 7/29/2024 to utilize Heelz-up [a device designed to aid in the prevention and treatment of heel pressure injuries which suspends the heels to eliminate pressure], while in bed. Record review of the resident's care plan dated 7/31/2024 revealed the resident has potential for developing a new pressure ulcer and alterations in skin integrity related to pressure ulcers, immobility, and incontinence of urine. The assessment further revealed that the resident has actual pressure ulcers on the right heel and coccyx. Surveyor observations on the following dates and times revealed the resident was lying in bed with his/her heels resting directly on the mattress and the Heelz-up device was observed on the bedside chair: -9/30/2024 at 9:25 AM -9/30/2024 at 12:17 PM -10/1/2024 at 3:30 PM -10/2/2024 at 10:07 AM Record review of the September and October 2024 Treatment Administration Records revealed that the staff signed off that the Heelz-up device was utilized while in bed on 9/30/2024,10/1/2024 and 10/2/2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further record review failed to reveal evidence that the resident refused the Heelz-up device during the above observations. During a surveyor interview on 10/2/2024 at 10:07 AM with the resident, s/he revealed that sometimes the staff off load his/her feet and sometimes they do not. During a surveyor interview on 10/2/2024 at approximately 10:09 AM with Licensed Practical Nurse (LPN), Staff E, she acknowledged that the resident has an order for his/her feet to be offloaded using the Heelz-up device and that his/her heels were resting directly on the mattress. During a surveyor interview on 10/2/2024 at 11:37 AM with Director of Nursing Services (DNS), he was unable to explain why the above-mentioned physician order was not followed. 2. Record review revealed that Resident ID #103 was admitted to the facility in March of 2024 with diagnoses including, but not limited to, right femur (thigh bone) fracture and muscle wasting. Record review revealed a physician's order dated 9/29/2024 to wash coccyx wound with Vashe (a wound cleanser that is a sterile, hypochlorous acid solution that replicates the body's natural defense against bacteria), mix medi-honey (a medical honey) with collagen powder (an absorbent wound powder) to form a paste then apply to the wound, apply skin prep (a liquid that when applied to the skin forms a protective film or barrier) to the peri wound (area around the wound), and cover with a foam bordered dressing. During a surveyor observation on 10/2/2024 at 9:29 AM with Registered Nurse, Staff C, she was observed to wash the wound with Vashe, applied skin prep to the peri wound and packed the wound with Puracol Plus AG with silver (a collagen dressing with added silver antimicrobial agent). She then proceeded to cover the wound with an absorbent dressing. During a surveyor interview immediately following the above-mentioned observation with Staff C, she acknowledged that she did not follow the physician's order for collagen powder mixed with medi-honey. During a surveyor interview on 10/2/2024 at 11:40 AM with the DNS, he was unable to explain why the above-mentioned physician's order was not followed.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 47939 Based on surveyor observation, record review, and staff interview it has been determined that the facility failed to meet professional standards of practice, in accordance with physician orders and the comprehensive person-centered care plan, relative to a peripherally inserted central catheter (PICC- a long, flexible tube that's inserted into a vein in the arm and threaded into a large vein near the heart, that is used to deliver medication or other treatments), for 1 of 1 resident observed for intravenous (IV) antibiotic administration, Resident ID #273. Findings are as follows: 1 a. Review of a facility policy dated August of 2021 titled, Vascular Access Devices and Infusion Therapy Procedures Dressing Change for Vascular Access Devices states in part, . Central Venous access device will be done at established intervals and immediately if the integrity of the dressing is compromised, if moisture, draining, or blood is present, or for further assessment if infection is suspected . a dressing is changed immediately if: The dressing is non-occlusive or soiled. There is drainage or moisture under the dressing . Assess site for Erythema [redness]. Indurtation [thickening or hardening of skin].Swelling.Drainage . measure external catheter length . Record review revealed that Resident ID #273 was readmitted to the facility in September of 2024 with diagnoses including, but not limited to, abscess of the right foot, cellulitis (a skin infection) of the right toe, ulcer to the right foot, and diabetes mellitus. Record review of the physician orders revealed the following: - 9/26/2024: Linezolid (an antibiotic) 0.9% sodium chloride 600 milligrams every 12 hours for cellulitis - 9/25/2024: Assess PICC site every shift - 9/25/2024: Monitor for signs and symptoms of abnormal bleeding related to anticoagulation therapy (treatment that reduces the ability of blood to clot) - 9/25/2024: Measure length of external (PICC) catheter daily Record review of the September 2024 Medication Administration Record revealed that the measurements of the external catheter were signed off as completed, although no measurements were documented. During a surveyor observation on 10/1/2024 at 9:14 AM, the resident was noted to have a PICC line in his/her right arm. The PICC was dressed with a Tegaderm (a clear dressing) and a 4 X 4 gauze covering the insertion site. The Tegaderm and the gauze were noted to be saturated with dried blood and approximately 1/4 of the Tegaderm was no longer adhering to the resident's skin. The resident's johnny also had a large area of dried blood covering approximately 12 inches by 12 inches. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 10/1/2024 at 12:34 PM with Licensed Practical Nurse (LPN), Staff F, she acknowledged the above observation and indicated that the dressing needed to be changed and she would change it. Record review failed to reveal evidence that on 10/1/2024 Staff F documented the status of the PICC or had changed the PICC line dressing after being brought to her attention by the surveyor. 1 b. Review of a facility policy dated August of 2021, titled Vascular Access Devices and Infusion Therapy Procedures Administration Set Change states in part, . Open the administration set and close all clamps . Hang the infusate [solution that will be infused] on the IV [Intravenous] pole and squeeze the drip chamber [collection chamber within the IV tubing] until approximately half full . If using IV pump to prime tubing (preparation of administration of IV medication tubing), place the tubing into the pump and prime per manufacture's guidelines . remove the sterile cover from the end of the administration set and attach to the needless connector on the IV catheter . During a surveyor observation of the medication administration task on 10/2/2024 at 9:44 AM with Registered Nurse, Staff C, she failed to close all the clamps after connecting the administration set to the antibiotic bag while priming, allowing approximately 20 milliliters (ml) of the medication to flow out of the tubing onto the medication cart. Additionally, Staff C, was observed entering the resident's room and removed the sterile cap from the end of the administration set. She then drained approximately 5 ml's into a plastic cup, placing the uncapped tubing on the resident's bed. Continued observation the PICC line dressing revealed a light red drainage covering the gauze under the Tegaderm. During a surveyor interview on 10/2/2024 immediately following the above observation with Staff C, she acknowledged that she did not prime per policy and stated, I'm not sure if there is another way to get the bubbles out. she indicated that there was light red drainage on the PICC line dressing, and it needed to be changed. She acknowledged that she should not have placed the uncapped IV tubing on the resident's bed. Record review failed to reveal evidence that Staff C changed the PICC line dressing per policy. During a surveyor interview on 10/2/2024 at 12:56 PM and 1 :25 PM with the Director of Nursing Services, he indicated that it would be his expectation for the residents IV to be primed per policy, that the residents PICC line dressing would be changed when moisture, drainage or bleeding is observed. Additionally, he indicated it would be his expectation of an assessment of the PICC line site and external catheter length would be documented in the residents' medical record.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 48928 Based on record review and staff interview, it has been determined that the facility failed to ensure that nursing staff have the appropriate competencies and skills sets to provide nursing and related services to assure resident safety to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment as required. Findings are as follows: Record review failed to reveal evidence that competencies and skills sets for wound vacuum-assisted closure (Wound VAC- a technique that uses negative pressure to pull the edges of a wound together and promote healing) device, peripherally inserted central catheter (PICC line, long, flexible tube that's inserted into a vein in the arm and threaded into a large vein near the heart, used to deliver medication or other treatments), and intravenous (IV) medication administration were completed for the following licensed nurses prior to it being brought to the attention of the facility by the surveyor on 9/30/2024: - Registered Nurse (RN), Staff G with a hire date of 4/19/2022 - RN, Staff C with a hire date of 10/5/2021 - Licensed Practical Nurse (LPN), Staff H with a hire date of 9/5/2023 - LPN, Staff F with a hire date of 12/18/2023 During a surveyor interview on 10/2/2024 at 11:24 AM with the Staff Development Coordinator, she was unable to provide evidence that competencies and skill sets relative to wound VAC care, PICC line dressings changes and intravenous medication administration were provided to license nurses prior to providing care. During a surveyor interview on 10/2/2024 at 12:44 PM with the Director of Nursing Services, he was unable to provide evidence that above mentioned education and competencies were completed prior to providing care. Cross reference: F684, F694, F726, and F880. 47939

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/04/2024
NAME OF PROVIDER OR SUPPLIER Friendly Home Inc The		STREET ADDRESS, CITY, STATE, ZIP CODE 303 Rhodes Avenue Woonsocket, RI 02895	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45263 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety relative to the main kitchen and 2 of 2 unit dining rooms. Findings are as follows: 1. The Rhode Island Food Code 2018 Edition 3.501.16, states in part, Time/Temperature Control for Safety Food Hot and Cold Holding .shall be maintained at .5 degrees C [Centigrade, which is 41 degrees Fahrenheit] or less . During a surveyor observation on 10/1/2024 at approximately 12:00 PM of the lunch meal service on the North unit, revealed turkey sandwiches had a cold holding temperature of 60 degrees F and chef's salads had a cold holding temperature of 59 degrees F. During a surveyor interview with the Food Service Director (FSD) immediately following the above mentioned observations, she acknowledged the food's were not within the acceptable cold holding temperature range. 2. The Rhode Island Food Code 2018 Edition 2-402.11, states in part, .food employees shall wear hair restraints, beard restraints that are designed and worn to effectively keep their hair from contacting exposed food . During a surveyor observation of the main kitchen on 9/30/2024 at approximately 9:30 AM, Dietary Aide, Staff I was observed with full facial hair and not wearing a beard restraint while assisting in dessert set up. During a surveyor observation on 10/1/2024 at approximately 12:30 PM, Staff I was observed assisting in serving beverages to residents in the North unit dining room without wearing a beard restraint. An additional surveyor observation on 10/2/2024 at approximately 12:00 PM, Staff I was observed assisting in serving beverages to residents in the [NAME] dining room without wearing a beard restraint. During a surveyor interview on 10/3/2024 at approximately 11:10 AM with the FSD, she acknowledged that Staff I was not wearing a beard restraint as required. 3. The Rhode Island Food Code 6.403.11 2018 Edition states in part, .because employees could introduce pathogens to food .areas designated to accommodate employees' personal needs must be carefully located . During a surveyor observation on 10/3/2024 at 12:30 PM in the main kitchen, a reach in refrigerator that stored desserts for residents revealed staff lunches were stored in the same refrigerator on the bottom shelf. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a surveyor interview with the FSD immediately following the above mentioned observation, she acknowledged that staff lunches should not be stored with facility purchased foods for residents.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47939 50004 21613 Based on record review and staff interview, it has been determined that the facility failed to document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies which must be reviewed and updated as necessary, and at least annually. Additionally, the facility failed to review and update the assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. Findings are as follows: Review of a facility provided document titled, Facility assessment dated [DATE] failed to reveal the following components as required: - The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population - The staff competencies that are necessary to provide the level and types of care needed for the resident population - The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population - Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services Further review of the document titled Facility Assessment, failed to reveal evidence of the facility's resources, which include but are not limited to: - Equipment (medical and non- medical) - Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies - All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care - Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and . (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a surveyor interview on 10/2/2024 at 3:33 PM with the Administrator, she acknowledged that the facility assessment failed to address the required components. Cross reference: F 684, F 694, F726, and F 880.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47939 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain Contact Precautions (an infection control intervention designed to reduce transmission of multidrug-resistant organisms in nursing homes) relative to wound care for 1 of 1 resident reviewed with Methicillin Resistant Staphylococcus (MRSA- a bacteria that is resistant to many antibiotics) in the nares and Vancomycin Resistant Enterococci (VRE- a bacteria resistant to antibiotics) in the wound, Resident ID #273. Additionally, the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections relative to 1 of 1 resident reviewed for wound care, Resident ID #103. Findings are as follows: 1. Review of the facility policy titled Guidelines for Management of MDROs [Multi- Drug Resistant Organisms] .CONTACT PRECAUTIONS .used with specific persons known or suspected to be infected .with .micro organisms that can be transmitted by direct contact with the person or indirect contact with environmental surfaces or equipment .VRE is spread by direct patient-to-patient via .hands of personnel or indirect contact on contaminated surfaces or equipment .can persist for weeks on environmental surfaces; special attention must be paid to housekeeping efforts . Record review revealed that Resident ID #273 was readmitted to the facility in September of 2024 with diagnoses including, but not limited to, abscess of the right foot, cellulitis (bacteria infection of the skin) of right toe, ulcer to the right foot, and diabetes mellitus. Record review revealed the following physician's orders: - 9/25/2024 maintain contact precautions for MRSA and VRE location in the wound. - 9/26/2024 wound vac, cleanse right heel with saline, skin prep (a liquid that when applied to the skin forms a protective film or barrier), peri wound (outside edges of wound), cut, and apply black foam to fit wound bed, cover with wound vac (Wound VAC, is a technique that uses negative pressure to pull the edges of a wound together and promote healing) once a day on Tuesday, Thursday, and Saturday. During a surveyor observation of the resident's wound care on 10/1/2024 at approximately 1:00 PM with the Staff Development Coordinator (SDC) and Licensed Practical Nurse (LPN) Staff F, revealed F was observed removing a urinal and other personal items from the bedside table. She failed to remove her gloves and perform hand hygiene prior to assisting the SDC with wound care for the resident. Staff F failed to clean the table prior to placing the wound care supplies for the treatment including scissors and gloves which were placed directly on the table. The SDC was observed cutting the resident's soiled dressing from his/her right heel wound with scissors, failed to clean the scissors before placing the scissors directly on the bedside table. Additionally, she was observed handling the uncapped and unclamped wound vac tubing without gloves. Staff F failed to perform hand hygiene prior to applying the new wound vac dressing, she also failed to clean the scissors prior to cutting the wound vac dressing and black foam sponge to fit the wound bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During subsequent observation at the completion of the wound care, the SDC placed the dirty scissors on the windowsill, then moved them on to the resident's sink counter. Lastly, she failed to clean the scissors prior to exiting the resident's room nor did she clean the bedside table, windowsill or counter after the treatment was completed. During a surveyor interview immediately following the above observation with the SDC, she acknowledged that Staff F failed to remove her gloves and perform hand hygiene. Additionally, she acknowledged that she failed to clean the resident's bedside table, clean the scissors after removing the soiled dressing, donn [put on] gloves while handling the wound vac tubing and to perform hand hygiene, and that she did not clean the surfaces and scissors prior to exiting the resident's room. During a surveyor interview on 10/2/2024 with the Director of Nursing Services (DNS), he revealed he would have expected that Staff F would have removed her gloves and performed hand hygiene prior to assisting with the wound treatment. The SDC should have cleaned the resident's bedside table, cleaned the scissors after removing the soiled dressing, donned gloves while handling the wound vac tubing and to perform hand hygiene, and she should have cleaned the surfaces and scissors prior to exiting the resident's room. 2. According to Infection Control Assessment and Response (ICAR) Tool for General Infection Prevention and Control (IPC) Across Settings .Wound Care Facilitator Guide from the Centers for Disease Control and Prevention last revised on 1/27/2023, states in part, .Maintain separation between clean and soiled equipment to prevent cross contamination .Any unused disposable supplies that enter the patient/resident's care area should remain dedicated to that patient/resident or be discarded. They should not be returned to the clean supply area. If supplies are dedicated to an individual patient/resident, they should be properly labeled and stored in a manner to prevent cross-contamination or use on another patient/resident (e.g., in a designated cabinet in the patient/resident's room) .Containers entering patient/resident care areas should be dedicated for single-patient /resident use or discarded after use . Record review revealed that Resident ID #103 was admitted to the facility in March of 2024 with a diagnosis including, but not limited to, displaced fracture of the neck of the femur (the bone of the thigh). Record review revealed the following physician's orders: -5/13/2024 Enhancer Barrier Precautions for wound care every shift -9/29/2024 Wash wound with Vashe (wound cleanser), mix medi-honey (medical honey) with collagen powder (absorbent wound powder) to form a paste then apply to the wound, skin prep around the wound, and apply foam bordered dressing three times per week (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor observation of the resident's wound care on 10/2/2024 at 9:29 AM, revealed Registered Nurse, Staff C, entering the residents room wearing a gown and gloves. She was then observed removing the resident's soiled dressing from his/her wound. She then removed her soiled gloves and proceeded to exit the resident's room while wearing the soiled gown to retrieve additional wound care supplies from the treatment cart. She failed to perform hand hygiene prior to exiting the residents room. Staff C then returned to the room wearing the same gown to complete the wound dressing. Further she was observed packing the wound dressing directly into the residents wound by pushing the dressing into the wound with her gloved finger. During a surveyor interview immediately following the surveyor observation, Staff C acknowledged that she did not remove her gown prior to exiting the residents room and inserted her gloved finger into the resident's wound rather than utilizing another implement such as a q tip. During a surveyor interview on 10/2/2024 at 10:42 AM and 3:57 PM, with the DNS, he revealed he would have expected the nurse to utilize a q tip to pack the residents wound and that she remove her gown and perform hand hygiene prior to exiting the resident's room to retrieving items from the treatment cart.