STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415060	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Nursing Home Inc	57 Stokes Street 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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 42399 Based on record review and staff interview, it has been determined that the facility failed to provide a written notice of transfer or discharge to the Office of the State Long-Term Care Ombudsman for 2 of 2 sample residents who were discharged to the hospital from the facility, Resident ID #s 13 and 14. Findings are as follows: 1. Record review revealed Resident ID #13 was originally admitted to the facility in November of 2018 with diagnoses including, but not limited to, syncope (loss of consciousness due to a drop in blood pressure) and collapse, chronic obstructive pulmonary disease and hypertension (high blood pressure). Record review revealed that the resident was discharged to the hospital on 2/2/2024. 2. Record review revealed Resident ID #14 was originally admitted to the facility in November of 2021 with diagnoses including, but not limited to, cerebral infarction (stroke), rhabdomyolysis (muscle tissue breaking down into the bloodstream), and spondylosis (degenerative disorder of the spine's bones and cartilage) in the lumbar region. Record review revealed that the resident was discharged to the hospital on 4/10/2024. Additional record review failed to reveal evidence that the Office of the State Long-Term Care Ombudsman was notified of the discharges for Resident ID #s 13 and 14. During a surveyor interview with the Director of Nursing Services in the presence of the Minimum Data Set Coordinator on 5/30/2024 at 3:22 PM, he was unable to provide evidence that the Office of the State Long-Term Care Ombudsman was notified of the above discharges to the hospital. Additionally, he indicated that he was unaware that there was a requirement to notify the Office of the State Long-Term Care Ombudsman when a resident is discharged from the facility.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 47279 Based on record review and staff interview, it has been determined that the facility failed to ensure that residents who require dialysis (a blood purifying treatment given when kidney function is not optimum) receive such services consistent with professional standards of practice for 1 of 1 resident reviewed for dialysis, Resident ID #19. Findings are as follows: Record review revealed the resident was admitted to the facility in March of 2021 with a diagnosis including, but not limited to, end stage renal disease (ESRD, when your kidneys can no longer support your body's needs). Record review of the resident's comprehensive care plan revealed that the resident receives dialysis three days a week on Tuesdays, Thursdays, and Saturdays at 9:45 AM. a) Record review failed to reveal evidence of a physician's order for dialysis to include the name of the center, the type of dialysis, and the scheduled days the resident is to receive dialysis. During a surveyor interview on 5/31/2024 at 10:23 AM with Registered Nurse, Staff A, she acknowledged that there was no order in place relative to dialysis that includes the above-mentioned information. b) Review of a facility policy titled, End-Stage Renal Disease, Care of a Resident with, states in part, . Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed . Record review revealed a document titled, Long Term Care Facility Outpatient Dialysis Services Care Coordination Agreement that states in part, This Agreement is made by and between [Facility] and [Dialysis Center], expressly for the purpose of care coordination .and is effective upon the date of last signature . Further review of the above-mentioned document failed to reveal evidence that it was signed and dated by either the dialysis center or the nursing facility. During a surveyor interview on 5/31/2024 at 11:17 AM with the Director of Nursing Services, he acknowledged that the dialysis service agreement lacked a signature and date from either party and was unable to explain why the facility nor dialysis center signed or dated the dialysis service agreement. He further revealed that it should be signed and dated by both parties. Additionally, he revealed that he was unaware that a physician's order relative to dialysis was required.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 47279 Based on record review, surveyor observation, resident and staff interview, it has been determined that the facility failed to meet the nutritional needs of residents relative to increased protein for 1 of 1 dialysis resident reviewed, Resident ID #19. Findings are as follows: Record review revealed that the resident was admitted to the facility in March of 2021 with diagnoses including, but not limited to, acute kidney failure and obesity. Additional review revealed that the resident requires dialysis (a blood purifying treatment given when kidney function is not optimum) three times per week. Review of the resident's care plan revealed an intervention including, but not limited to, provide ordered diet. Review of a physician's order dated 3/15/2024 revealed the resident is to have double portions of protein with each meal. Review of a dialysis plan note for February 2024 revealed that the resident's albumin (protein in blood) in February 2024 was 3.1 and below the goal of 4 or higher. Review of the resident's meal ticket for breakfast, lunch and dinner revealed s/he is to have double portions of protein with each meal. During a surveyor observation on 5/29/2024 at 12:19 PM of the resident's lunch tray revealed shepards pie with brussel sprouts. Additionally, the serving was not double protein as ordered. During an interview with the resident directly following the above observation, s/he revealed that s/he would like to get the double portions of protein with each meal but rarely does. During a surveyor observation on 5/30/2024 at 8:22 AM of the resident's breakfast tray revealed a biscuit and cream of wheat cereal. Additionally, no protein was observed on the resident's meal tray. During a surveyor observation on 5/30/2024 at 12:22 PM of the resident's lunch tray revealed a bowl of beef stew and a bowl of peaches. Additionally, the serving of beef stew was not double protein as ordered. During a surveyor interview on 5/30/2024 at 12:30 PM with Cook, Staff M, she revealed that the resident does not get protein in the morning unless there is bacon or sausage because s/he does not like eggs. The resident typically gets a large bowl of cereal for breakfast. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 5/30/2024 at 3:32 PM with the Registered Dietitian she revealed that she was unaware that the resident was not getting the double protein portions as ordered. Additionally, she revealed that she would expect the staff to provide substitute protein options if the resident does not like what is being served. During a surveyor interview on 5/31/2024 at 10:38 AM with the Director of Nursing Services he was unable to provide evidence that the facility was providing the resident with double portions of protein at each meal, as ordered.

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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. 42399 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 service safety, relative to the main kitchen. Findings are as follows: 1. Record review of the Rhode Island Food Code, 2018 Edition, section 4-601.11 states in part, .(B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT .shall be kept free of encrusted grease deposits and other soil accumulations. (C) NON-FOOD CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris . During the initial tour of the main kitchen on 5/29/2024 at 8:55 AM and 9:15 AM in the presence of the Administrator, the following was observed: - A microwave on the back counter was noted to have dried food particles, orange and brown in color, on the inside of the door, walls, ceiling and glass turning plate. - In the refrigerator labeled as the Defrosting Fridge in the basement, there were two wrapped pieces of red meat resting directly on the shelves. The bottom of the refrigerator was covered in red liquid, both stained and wet. 2. Record review of the Rhode Island Food Code, 2018 Edition, Section 3-501.17 states in part, Ready-to Eat, Time/Temperature Control for Safety, Date Marking .(B) .(1) The day the original container is opened in the Food establishment shall be counted as Day 1 . During the initial tour of the main kitchen on 5/29/2024 at 8:55 AM in the presence of Cook, Staff B, the following was observed in the refrigerator labeled [NAME] Fridge/Freezer: - One 46 ounce (oz) nectar thickened apple juice opened and not dated. Manufacturer's instructions indicate to use the product within 10 days upon opening. - One 46 oz nectar thickened sugar free peach mango juice opened and not dated. Manufacturer's instructions indicate to use the product within 10 days upon opening. - One 46 oz nectar thickened cranberry juice opened and not dated. Manufacturer's instructions indicate to use the product within 10 days upon opening. During a surveyor interview with Staff B at the time of the above observation, she acknowledged that the nectar thickened juices should have been dated when opened. During a surveyor interview with the Administrator on 5/29/2024 at approximately 9:15 AM, he acknowledged that the microwave and refrigerator were dirty and needed to be cleaned and that the nectar thickened juices should have been dated when opened.

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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.

45855

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 (IPCP) to help prevent the transmission of communicable diseases and infections for 2 of 3 residents reviewed for multidrug-resistant Organisms (MDRO), Resident ID #s 6 and 28. Additionally, the facility failed to conduct appropriate infection control practices relative to personal protective equipment during foley catheter (a flexible tube that is inserted through the urethra to help drain urine from the bladder) removal for 1 of 1 resident observed, Resident ID #3. The facility further failed to implement a water management program based upon industry standards and/or the Centers for Disease Control and Prevention (CDC) toolkit and to perform and document specified testing for the prevention of Legionella disease (a very serious type of lung infection caused by the bacteria called Legionella which can be found in water). This deficient practice could impact 31 of 31 residents, as well as an indeterminable number of staff and visitors.

Findings are as follows:

Review of the Centers for Disease Control and Prevention's (CDC) document titled, Multidrug-resistant organisms management states in part, .For ill residents (e.g. those totally dependent upon healthcare personnel for healthcare and activities of daily living) .use Contact Precautions [use of gown and gloves when entering a resident's room] in addition to Standard Precautions .

Review of a facility policy titled Isolation - Categories of Transmission-Based Precautions states in part, . Contact precautions are also used in situations when a resident is experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and suggest an increased potential for extensive environment contamination and risk of transmission of a pathogen, even before specific organism has been identified .Contact precautions are used for residents infected or colonized [If you are colonized with an MDRO, these germs are living on or in your body. You may not be sick with an infection, but you can still spread the infection] with MDROs in the following situations .when a resident has wounds, secretions, or excretions that are unable to be covered or contained .the individual on contact precautions is placed in a private room if possible .

Review of a policy title Enhanced Barrier Precautions last revised on 1/8/2024 states in part, Post the appropriate Enhanced Barrier Precautions (EBP) sign on the patient's room door .Enhanced Barrier Precautions (EBP) are to be utilized for the duration of the patients stay .All patients with any of the following: Infection or colonization with an MDRO when Contact Precautions do not apply .PPE Used for These Situations .During high contact patient care activities: Dressing .bathing/showering .transferring .providing hygiene .changing linens .changing briefs or assisting with toileting .device care or use, central line, urinary catheter, enteral feeding .

1 a. Record review revealed that Resident ID #6 was readmitted to the facility in May of 2024 with diagnoses including, but not limited to, Vancomycin-resistant Enterococci (VRE, a type of bacteria present in the gastrointestinal tract that develop resistance to many antibiotics, especially vancomycin.)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a care plan dated 5/21/2024 revealed s/he tested positive for VRE. Interventions include, but are not limited to, contact precautions. Review of a hospital continuity of care form dated 5/6/2024-5/15/2024 revealed, Isolation Status s/he was on infection control precautions for VRE. During a surveyor observation on 5/29/2024 at 9:00 AM of the resident's room revealed a sign for contact precautions. The sign states in part, Everyone must put on gloves before room entry .put on a gown before room entry . During a surveyor observation on 5/29/2024 at 9:52 AM of Registered Nurse, Staff C, she obtained the resident's vital signs without wearing a gown or gloves. During a surveyor interview immediately following the above observation on 5/29/2024 with Staff C, she acknowledged that she should have worn a gown and gloves as required. Additionally, she acknowledged the resident was on contact precautions related to VRE. During a surveyor observation on 5/29/2024 at 12:24 PM of the Director of Nursing Services (DNS), he entered the resident's room and lifted the residents blanket up to assess his/her legs without wearing a gown or gloves. During a surveyor interview immediately following the above observation with the DNS, he acknowledged that he should have worn a gown and gloves to enter the resident's room as required. Additionally, he acknowledged the resident was on contact precautions for VRE. During a surveyor observation on 5/29/2024 at 2:10 PM of Physical Therapist Assistant, Staff D, entered the resident's room without wearing a gown or gloves and performed therapeutic exercises with the resident for approximately 20 minutes. During a surveyor interview immediately following the above observation with Staff D, she acknowledged that she should have worn a gown and gloves to enter the room per the signage on the resident's door but was unaware of why the resident was on contact precautions. During a surveyor interview on 5/30/2024 at 10:06 AM with the DNS, he revealed that the resident was on contact precautions for VRE and would expect staff to wear a gown and gloves when entering the resident's room. 1 b. Record review revealed that Resident ID #28 was readmitted to the facility in February of 2024 with a diagnosis including, but not limited to, cerebral infarction (stroke). Review of a urine culture dated 4/29/2024 revealed that s/he is positive for extended-spectrum beta-lactamase (ESBL, infection resistant to common antibiotics and may require complex treatments). Review of a urine culture dated 5/18/2024 revealed that s/he is positive for ESBL and was treated with antibiotics from 5/20/2024 through 5/27/2024. Record review failed to reveal evidence of a re-culture to determine if the resident remained positive for ESBL. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During surveyor observations from 5/29/2024 through 5/31/2024 revealed the resident was not on contact precautions. During a surveyor interview on 5/31/2024 at approximately 9:00 AM with Registered Nurse, Staff A, she revealed that the resident was not on any precautions after completing his/her antibiotic treatment for ESBL. During a surveyor interview on 5/31/2024 at 11:17 AM with the DNS, he acknowledged that Resident ID #28 was not on contact precautions or EBP per the CDC, Rhode Island Department of Health and the facility policy. Additionally, he 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 MDROs. 2. Record review revealed that Resident ID #3 was admitted to the facility in April of 2024 with a diagnosis including, but not limited to, acute kidney failure. Review of a physician's order dated 5/24/2024 states in part, Insert 16 Fr [French] 3-way foley .for irrigation . (Foley to be removed immediately following treatment) . During a surveyor observation on 5/30/2024 at approximately 8:30 AM of the resident's room failed to reveal evidence that s/he was on EBP. Further observation revealed Registered Nurse, Staff A, removing the resident's foley catheter while wearing only gloves. She was not observed to be wearing a gown relative to enhanced barrier precautions. During a surveyor interview immediately following the above observation with Staff A, she indicated that she only needs gloves to remove the foley catheter and no other precautions were necessary. During a surveyor interview on 5/30/2024 at 10:06 AM with the DNS, he revealed that the resident should be on enhanced barrier precautions and the nurse should be wearing a gown and gloves during foley catheter insertion and removal. 3. Record review of the CDC document titled, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings, dated June 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 . During a surveyor interview with the Administrator on 5/29/2024 at approximately 8:00 AM he revealed that the facility has not been flushing any empty rooms as they are at full capacity. Additionally, he revealed that there were no unused sinks in the facility. Surveyor observation of a shower room on 5/30/2024 at 9:15 AM located in a housekeeping room, revealed there was a shower that was not in use. Further observation of the facility revealed a utility room with two sinks that were not in use. During a surveyor interview at the time of the above-mentioned observations with the Administrator, he indicated that the shower and the two sinks were not being utilized by anyone in the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the facility's water management binder failed to reveal evidence that the water flow assessment was filled out in its entirety to indicate how many sinks, toilets, and water reservoirs were in place. Further review of the water management binder failed to reveal evidence that the facility conducted flushing maintenance of the unused shower and sinks that were identified on 5/30/2024. During a surveyor interview with the Administrator on 5/30/2024 at 11:50 AM, he was unable to provide evidence that the facility maintained or implemented a water management program based upon industry standards and the CDC toolkit for the prevention of Legionella, as required. During a surveyor interview on 5/31/2024 at 9:14 AM with the DNS he 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. 47279 46715 50004

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 46241 Based on record review and staff interview it has been determined that the facility failed to develop, implement, and maintain an effective training program, which includes but is not limited to communication, residents rights, abuse, quality assurance and performance improvement, infection control and behavioral health, for all new and existing staff consistent with their expected roles for 4 of 4 staff members reviewed, Staff C, E, F and G. Findings are as follows: Record review revealed that Registered Nurse, Staff C, was hired on 3/27/2019. Additional review revealed that Staff C did not receive any mandatory education in 2023. Record review revealed that Registered Nurse, Staff E was hired on 2/15/2022. Additional review revealed that Staff E did not receive any mandatory education in 2023. Record review revealed that Certified Medication Technician (CMT), Staff F was hired on 2/17/2014. Additional review revealed that Staff F did not receive any mandatory education for all of 2023. Further review revealed that she has not received an annual performance evaluation or 12 hours of mandatory in-services as required. Record review revealed that Nursing Assistant, Staff G was hired on 7/5/2017. Additional review revealed that Staff G did not receive any mandatory education for all of 2023. Further review revealed that he has not received an annual performance evaluation or 12 hours of mandatory in-services as required. During a surveyor interview on 5/30/2024 at 12:03 PM with the Director of Nursing Services, he was unable to provide evidence of any mandatory education for 2023 for any of the above mentioned staff. Additionally, he was unable to provide evidence of annual performance reviews or proof of 12 hours of inservice training for the Staff F and G.