

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415075	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Holiday Retirement Home Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 30 Sayles Hill Road Manville, RI 02838	

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)
<p>F 0687</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46715</p> <p>Based on record review and staff interview it has been determined that the facility failed to ensure that residents receive foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) relative to peripheral vascular disease for 1 of 3 residents reviewed, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Record review revealed that the resident was readmitted to the facility in August of 2024 with diagnoses including, but not limited to, cellulitis (a bacterial infection of the skin and the soft tissues underneath) and peripheral vascular disease (a condition where narrowed arteries reduce blood flow to the arms or legs).</p> <p>Review of a Minimum Data Set assessment dated [DATE] revealed the resident is dependent for lower body dressing and putting on/taking his/her shoes.</p> <p>Review of a community reported complaint received by the Rhode Island Department of Health on 8/14/2024 alleged that the resident was treated at the hospital on 8/4/2024 for multiple wounds to his/her feet that were infested with maggots.</p> <p>Review of photographs taken at the hospital dated 8/4/2024 revealed wounds between multiple toes with visible black tissue and white maggots.</p> <p>Review of hospital admission paperwork for Resident ID #1 dated 8/4/2024 states in part, .Upon removing a kerlix dressing to [the resident's] rt [right] foot noted to have old blood, black colored tissue with maggots in between toes, top of right foot with redness. Pedal pulse weak .Seen by house resident, and supervisor, cleansed extensively with wound cleanser to partially remove many maggots and left open to air .</p> <p>Further review of the hospital admission paperwork dated 8/4/2024 revealed s/he was admitted to the hospital with cellulitis to the right lower extremity and started on intravenous antibiotics.</p> <p>Review of a skin assessment completed by Registered Nurse (RN), Staff A, dated 8/3/2024 revealed the resident had dry skin to his/her bilateral lower extremities, but the wounds to his/her feet were not identified.</p> <p>(continued on next page)</p>

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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<p>F 0687</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview on 8/19/2024 at 9:40 AM with RN, Staff A, she revealed that she completed the skin assessment on 8/3/2024 and did not note any wounds to the resident's feet. Additionally, she revealed that she did not look between the resident's toes to assess the skin in those areas.</p> <p>During a surveyor interview on 8/19/2024 at 10:03 AM with Nursing Assistant, Staff B, he revealed that he gave the resident a shower on 8/3/2024 and did not notice any wounds to his/her feet.</p> <p>During a surveyor interview on 8/19/2024 at approximately 10:30 AM with Licensed Practical Nurse (LPN), Staff C, she revealed that she assisted in applying a dressing to the resident's wounds between his/her toes on 8/3/2024. Additionally, she revealed she witnessed a fairly good sized wound with something moving inside the wound and redness to the resident's leg. Staff C further revealed that the resident's right leg was warm to the touch and s/he complained of sensitivity to his/her leg. Lastly, Staff C, revealed that a wound was visible without having to spread the resident's toes.</p> <p>Review of wound assessments dated 8/8/2024 revealed the following vascular wounds:</p> <p>Right foot toe interspaces</p> <ul style="list-style-type: none"> -Between toes 1 and 2 - 3.3 centimeter (cm) x 1.0 cm -Between toes 2 and 3 - 2.5 cm x 0.5 cm -Between toes 3 and 4 - 3.5 cm x 1.2 cm -Between toes 4 and 5 - 2.0 cm x 1.5 cm <p>Left foot toe 4 plantar 0.4 cm x 0.3 cm x 0.1 cm</p> <p>During a surveyor interview on 8/19/2024 at 1:40 PM with the Director of Nursing Services (DNS), he revealed that he would expect the staff to complete a full skin assessment including between a resident's toes. Additionally, he revealed that the facility does not have any standing orders for preventive care to avoid podiatric complications in residents with diabetes and circulatory disorders who are prone to developing foot problems. The DNS was unable to provide evidence that the facility provided preventative foot care for Resident ID #1.</p> <p>Cross reference F 726</p>		

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<p>F 0726</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>46715</p> <p>Based on record review and staff interview, it has been determined that the facility failed have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident relative to skin assessments for 6 of 6 licensed nursing staff reviewed, Staff IDs A, C, D, E, F and G.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled, Skin Care Program states in part, .The weekly skin assessments (documented under assessments) will be done for every resident .</p> <p>Review of the 2024 Facility Assessment revealed competencies to be provided to staff including, Resident assessment and examinations .skin assessment .</p> <p>Review of a community reported complaint received by the Rhode Island Department of Health on 8/14/2024 alleged that the resident was treated at the hospital on 8/4/2024 for multiple wounds to his/her feet. Additionally, maggots were present in the wounds.</p> <p>Review of photographs taken at the hospital dated 8/4/2024 revealed wounds between multiple toes with visible black tissue and white maggots.</p> <p>Review of hospital admission paperwork for Resident ID #1 dated 8/4/2024 states in part, .Upon removing a kerlix dressing to [the resident's] rt [right] foot noted to have old blood, black colored tissue with maggots in between toes, top of right foot with redness. Pedal pulse weak .Seen by house resident, and supervisor, cleansed extensively with wound cleanser to partially remove many maggots and left open to air .</p> <p>Further review of the hospital admission paperwork revealed s/he was admitted with cellulitis to the right lower extremity and started on intravenous antibiotics.</p> <p>Review of a skin assessment completed by Registered Nurse (RN), Staff A dated 8/3/2024, the day prior to the resident's hospitalization , revealed that the resident had dry skin to his/her bilateral lower extremities and foot wounds were not identified.</p> <p>During a surveyor interview on 8/19/2024 at 9:40 AM with RN, Staff A, she revealed that she completed the skin assessment on 8/3/2024 and did not note any wounds to the resident's feet. Additionally, she revealed that she did not look in between the resident's toes to assess the skin in those areas.</p> <p>Record review of 6 licensed nursing staff (Staff IDs A, C, D, E, F and G) competencies failed to reveal evidence that they received competency-based training on skin assessments.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview on 8/19/2024 at 1:40 PM with the Director of Nursing Services (DNS), he revealed that he would expect the nursing staff to assess the skin between a resident's toes during a skin assessment.</p> <p>During a surveyor interview on 8/19/2024 at approximately 2:30 PM with the DNS and the Assistant Director of Nursing, they acknowledged that they do not provide competencies for the nursing staff regarding completing or documenting a skin assessment. Additionally, they were unable to provide evidence that the facility followed their facility assessment in regards to competency based training on skin assessments.</p> <p>The failure of the facility to accurately and thoroughly conduct skin assessments to ensure identification of wounds placed not only Resident ID #1 at risk for serious injury, serious harm, serious impairment or death, but all of the facility's 150 residents who require weekly skin assessments.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>46715</p> <p>Based on record review and staff interview, it has been determined that the facility failed to maintain medical records on each resident that are complete and accurately documented relative to skin assessments for 1 of 3 residents reviewed, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled, Skin Care Program states in part, .Weekly skin assessments will be done and documented appropriately .</p> <p>Review of a community reported complaint received by the Rhode Island Department of Health on 8/14/2024 alleged that the resident was treated at the hospital on 8/4/2024 for multiple wounds to his/her feet that contained maggots.</p> <p>Review of photographs taken at the hospital dated 8/4/2024 revealed the resident had wounds between multiple toes with visible black tissue and white maggots.</p> <p>Review of hospital admission paperwork for Resident ID #1 dated 8/4/2024 states in part, .Upon removing a kerlix dressing to [the resident's] rt [right] foot noted to have old blood, black colored tissue with maggots in between toes, top of right foot with redness. Pedal pulse weak .Seen by house resident, and supervisor, cleansed extensively with wound cleanser to partially remove many maggots and left open to air .</p> <p>Further review of the hospital admission paperwork revealed the resident was admitted with cellulitis to the right lower extremity and was started on intravenous antibiotics.</p> <p>Review of a skin assessment completed by, Registered Nurse (RN), Staff A dated 8/3/2024, the day prior to the resident's hospitalization , revealed that the resident had dry skin to his/her bilateral lower extremity and foot wounds were not identified.</p> <p>During a surveyor interview on 8/19/2024 at 9:40 AM with RN, Staff A, she revealed that she completed the skin assessment on 8/3/2024 and did not note any wounds to the resident's feet. Additionally, she revealed that she did not look in between the resident's toes to assess that skin in those areas.</p> <p>During a surveyor interview on 8/19/2024 at 1:40 PM with the Director of Nursing Services he revealed that he would expect the nursing staff to assess the skin between a resident's toes during a skin assessment. Additionally, he was unable to provide evidence that the skin assessment was completed accurately for Resident ID #1.</p>		