

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415079	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2024
NAME OF PROVIDER OR SUPPLIER Trinity Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4 St Joseph Street 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)
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for 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>41542</p> <p>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 skill sets to provide nursing and related services to assure resident safety, relative to a peripherally inserted central catheter (PICC- which is inserted into a vein in the arm and passed through to the larger veins near your heart), for 1 of 1 resident reviewed, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Record review of the facility assessment, last revised in January of 2024, revealed that the facility has the ability to provide intravenous (IV) therapy to their residents.</p> <p>Record review revealed Resident ID #1 was admitted to the facility in June of 2024 with diagnoses including, but not limited to, type II diabetes mellitus, acute kidney injury, infection and inflammatory reaction due to internal fixation device of unspecified site, and sepsis (potentially life-threatening infection of the blood stream).</p> <p>Additionally record review revealed that upon admission, the resident had a PICC line and was prescribed to receive IV antibiotics through the PICC line once every 24 hours.</p> <p>Review of the 2024 Education Series for Registered Nurses and Licensed Practical Nurses failed to reveal education, competencies and skills sets related to PICC line care or the administration of IV therapy.</p> <p>Record review of a document sent after the surveyor exited the facility revealed a 2022 RIHCA [Rhode Island Health Care Association] Competency Training which revealed that 6 of the facility's 60 nurses were trained in midline and PICC dressing and removal.</p> <p>During a surveyor interview on 6/21/2024 at approximately 4:00 PM, with the Director of Nursing Services, he was unable to provide evidence that PICC line competencies and skill sets were completed for all Registered Nurses and Licensed Practical Nurses.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>41542</p> <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on record review and staff interview, it has been determined that the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological's) to meet the needs of each resident for 1 of 3 residents reviewed, Resident ID #1.</p> <p>Record review of a community reported complaint received by the Rhode Island Department of Health on 6/19/2024 alleges that Resident ID #1 has not received his/her methadone (a medication used to treat opioid use disorder) and other medications for two days. The complaint further indicates that the resident tried to speak with the facility staff about this and was told they were checking with the pharmacy.</p> <p>Record review for Resident ID #1 revealed s/he was admitted to the facility in June of 2024 with diagnoses including, but not limited to, sepsis (a potentially life-threatening infection in the blood), history of opioid abuse, type II diabetes mellitus, acute kidney injury, and infection and inflammatory reaction due to internal fixation device (surgical procedure used to internally set and stabilize fractured bones).</p> <p>Record review of the June 2024 Medication Administration Record (MAR) revealed s/he did not receive the following medications as ordered on the following dates and times:</p> <ul style="list-style-type: none"> - Daptomycin-Sodium Chloride Intravenous Solution (an antibiotic) 500-0.9 MG (milligrams)/50 ML (milliliters), 560 mg intravenously in the morning for infection. Not administered on 6/18/2024. - Methadone HCL Oral Concentrate 10 mg/ml. Give 11 ml (110 mg) by mouth two times a day. Not administered on , 6/18/2024 AM and PM doses, 6/19/2024 AM and PM doses, and 6/20/2024 AM dose. This indicates the resident missed a total of five doses of methadone over a three day period. <p>Further review of the MAR notes for the above-mentioned medications revealed they were not administered to the resident as they were unavailable.</p> <p>Record review failed to reveal evidence that a pharmacy obtained and delivered the above-mentioned medications for the resident.</p> <p>During a surveyor interview on 6/21/2024 at 10:45 AM with an employee of the pharmacy that provides methadone to the facility, Staff A, she revealed that the pharmacy received the paperwork from the facility on 6/18/2024 at approximately 11:00 AM. She indicated that 11:00 AM was too late to fill the methadone order because the courier who delivers the methadone is on the road by noon and they deliver once every day.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During a surveyor interview on 6/21/2024 at approximately 1:00 PM with the Director of Nurses and Licensed Practical Nurse, Staff B, they indicated that they use one pharmacy to deliver methadone to the facility and another pharmacy delivers all other medications. Additionally, they acknowledged that the resident never received his/her methadone or the first dose of his/her antibiotic, as neither were available for administration due to the pharmacies not delivering them.</p> <p>Cross Reference F 760</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>41542</p> <p>Ensure that residents are free from significant medication errors.</p> <p>Based on record review and staff interview it has been determined that the facility failed to ensure that residents are free significant medication errors for 1 of 1 resident reviewed, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Record review of a community reported complaint received by the Rhode Island Department of Health on 6/19/2024 alleges that Resident ID #1 has not received his/her methadone (a medication used to treat opioid use disorder) and other medications for two days. The complaint further indicates that the resident tried to speak with the facility staff about this and was told they were checking with the pharmacy.</p> <p>Record review revealed Resident ID #1 was admitted to the facility in June of 2024 with diagnoses including, but not limited to, sepsis (a potentially life-threatening infection in the blood), history of opioid abuse, type II diabetes mellitus, acute kidney injury, and infection and inflammatory reaction due to internal fixation device (surgical procedure used to internally set and stabilize fractured bones).</p> <p>1a. Review of a physician's order dated 6/17/2024 at 8:42 PM revealed an order for methadone HCL Oral Concentrate 10 milligrams/milliliters. Give 11 ml (110 mg) by mouth two times a day.</p> <p>Review of the June 2024 Medication Administration Record failed to reveal evidence that the methadone was administered on 6/18/2024 AM and PM doses, 6/19/2024 AM and PM doses, and 6/20/2024 AM dose. This indicates the resident missed a total of five doses of methadone over a three day period.</p> <p>During a surveyor interview on 6/21/2024 at 10:45 AM with an employee of the pharmacy that provides methadone to the facility, Staff A, she revealed that the pharmacy received the paperwork from the facility on 6/18/2024 at approximately 11:00 AM. She indicated that 11:00 AM was too late to fill the methadone order because the courier who delivers the methadone is on the road by noon and they deliver once every day.</p> <p>1b. Review of a physician's order dated 6/17/2024 revealed an order for Daptomycin-Sodium Chloride Intravenous Solution (an antibiotic) 500-0.9 MG (milligrams)/50 ML (milliliters), 560 mg intravenously in the morning for infection.</p> <p>Review of the June 2024 Medication Administration Record failed to reveal evidence that Daptomycin-Sodium Chloride Intravenous Solution was administered on 6/18/2024.</p> <p>During a surveyor interview with the Director of Nursing Services and Licensed Practical Nurse, Staff B, on 6/21/2024 at approximately 11:00 AM, they acknowledged that the resident never received methadone and missed his/her 6/18/2024 dose of Daptomycin-Sodium Chloride Intravenous Solution while s/he resided at the facility.</p> <p>Cross Reference F 755</p>		