STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415106	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Antoine Residence	10 Rhodes Avenue North Smithfield, RI 02896

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47939 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 4 residents reviewed for pressure ulcers, Resident ID #s 38 and 153. Findings are as follows: Record review of a facility policy dated May of 2019 titled, Skin Integrity Management states in part, all residents receive care, consistent with professional standards of practice, to prevent pressure ulcers so they do not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable .the care plan is developed based on the resident assessment .The care plan includes, for a resident who has skin integrity issues or pressure injury or is at risk for pressure injury .skin check are completed and documented by a nurse weekly . 1. Record review revealed that Resident ID #153 was readmitted to the facility in January of 2024 with diagnoses including, but not limited to, stroke with left hemiplegia (a symptom that involves one-sided paralysis) and hemiparesis (one sided muscle weakness). Record review of the Annual Minimum Data Set Assessment (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) with a score of 7 out of 15, indicating the resident has severe cognitive impairment. Record review of the resident's care plan dated 1/20/2024 revealed the resident is at risk for impaired skin integrity related to incontinence with an intervention including, but not limited to, utilize pressure relieving devices on appropriate surfaces. Record review revealed a physician's order dated 9/3/2024 to offload heels (relieve pressure) at all times. Record review of a Skilled Wound Care Surgical Note dated 10/15/2024 indicated that the resident has a Deep Tissue Pressure Injury (DTI-a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure) to his/her left heel. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor observations on the following dates and times failed to reveal evidence that the resident's heels were offloaded as ordered: -10/21/2024 at approximately 11:30 AM -10/22/2024 at 9:37 AM -10/23/2024 at 8:59 AM During a surveyor interview on 10/24/2024 at 10:44 AM with Licensed Practical Nurse (LPN), Staff E, she acknowledged that the resident has an order for his/her feet to be off loaded and that the staff failed to off load his/her heels per the physician order. 2. Record review revealed that Resident ID #38 was admitted to the facility in January of 2019 with a diagnosis including, but not limited to, protein calorie malnutrition (a state of inadequate intake of food as a source for protein and calories). Record review of a Braden Scale for predicting pressure sore risk dated 4/29/2024 revealed a score of 15 out of 18, indicating the resident is at risk for the development of pressure injuries. Record review revealed a physician's order dated 8/13/2024 to off load both heels every shift for prevention of skin breakdown. Surveyor observations on the following dates and times failed to reveal evidence that the resident's heels were off loaded as ordered: -10/20/2024 at 10:01 AM and 11:40 AM -10/21/2024 at 9:10 AM and 11:30 AM -10/22/2024 at 9:30 AM and 11:08 AM -10/23/2024 at 9:00 AM During a surveyor interview on 10/23/2024 at 9:12 AM with LPN, Staff F, she acknowledged that Resident ID # 38's heels were not offloaded during the above-mentioned observations. During a surveyor interview on 10/23/2024 at approximately 1:00 PM and on 10/24/2024 at 1:03 PM with the Director of Nursing Services, she indicated that she would expect the staff to follow the physician's orders for offloading heels.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 41542 Based on record review and staff interview, it has been determined that the facility failed to ensure that a Nurse Practioner provide orders for the resident's immediate care and needs for 1 of 1 resident reviewed for physician orders with acute urinary retention (inability to empty the bladder) Resident ID #153. Findings are as follows: Record review revealed Resident ID #153 was admitted to the facility in October of 2023 with diagnoses including, vascular dementia (a type of dementia cause by brain damage from impaired blood flow) and cerebrovascular disease (a term for conditions that affect blood flow to your brain). Record review of a progress note dated 10/21/2024 authored by Nurse Practitioner (NP), Staff J, documented as a late entry for 10/17/2024 states in part, .Patient was noted with abnormal weight gain, increased edema as well as hypotension and at that time last week this writer ordered bladder scans,[s/he] was noted to be retaining urine again and a foley catheter was inserted, unfortunately a urine was not sent to the lab for culture and sensitivity as was ordered, on exam today that patient was slurring words and very disoriented from [his/her] baseline, nursing will need to obtain a urine and send it to the lab for culture and sensitivity as [s/he] is likely has an acute cystitis [bladder infection] . Record review of the physician's orders failed to reveal evidence that an order was written for a urine culture and sensitivity. During a surveyor interview on 10/24/2024 at 1:03 PM, with Licensed Practical Nurse, Staff E she revealed that she was not aware that the resident required a urine culture and sensitivity. During a surveyor interview on 10/24/2024 at 11:46 AM with Staff J, she acknowledged that she failed to provide an order to obtain a urine culture and sensitivity prior to 10/17/2024 or on 10/17/2024 when she noted the resident to have an acute change in condition. During a surveyor interview with the Medical Director on 10/24/2024 at 4:21 PM, he indicated that he would expect the NP to follow up and provide an order for a urine culture and sensitivity for the resident. 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. Findings are as follows: 1. The [NAME] Food Code, 2018 Edition, 4-601.11 states in part, .Nonfood contact surfaces shall be kept free of an accumulation of dirt, dust, food residue, and other debris . During surveyor observations on 10/20/2024 at 8:50 AM, 10/21/2024 at 12:41 PM and 10/23/2024 at approximately 2:00 PM of the main kitchen on the following was observed: -Dust and grease accumulation on the [NAME] hood system, including the spray heads and light fixtures. -Dust and grease accumulation along the sides of the stove. -Dust and grease accumulation along the inner front of the flat top griddle. -Corners of the convection oven with an accumulation of grease and grime. -the floor behind all kitchen equipment, including worktables and the ice machine had an accumulation of dust and debris. 2. The Rhode Island Food Code, 2018 Edition, 2-302.11 Fingernails Maintenance states in part, .unless wearing intact gloves in good repair, a food employee may not wear fingernail polish or artificial fingernails when working with expose food . During surveyor observations on 10/20/2024 at 8:50 AM, 10/21/2024 at 12:41 PM and 10/23/2024 at approximately 2:00 PM of the main kitchen, Dietary Cook, Staff I, was observed with acrylic nails while working in the main kitchen without wearing gloves. 3. The [NAME] Food Code 2018 Edition 5-501.113 Covering Receptacles states in part, .receptacles shall be kept covered .and are not in continuous use . During surveyor observations on 10/20/2024 at 8:45 AM, 10/22/2024 at 12:41 PM and 10/23/2024 at 2:00 PM of the main kitchen the following was observed: -A trash container with refuse that was stored by a bread rack was uncovered and not in use. -A trash container with refuse that was stored by a worktable across from the convection oven was uncovered and not in use. (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 on 10/24/2024 at approximately 11:30 AM with the Food Service Director, he acknowledged the large equipment and the hood over the stove was in need of cleaning, that the dietary cook had acrylic nails and was not wearing gloves during any type of food preparation and/or service and that the trash containers were not covered in the main kitchen when they were not in use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 to help prevent the transmission of communicable diseases and infections relative to 3 of 3 residents reviewed for wound care, Resident ID #s 77,153, and 162. Additionally, the facility failed to maintain Enhanced Barrier Precautions (EBP; an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO] in nursing homes) for 2 of 4 residents reviewed with pressure injuries, Resident ID #s 77 and 146. Findings are as follows: 1. According to the 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 . 1a. Record review revealed Resident ID #77 was admitted to the facility in August of 2017 with a diagnosis including, but not limited to a pressure ulcer of the sacral region. Record review revealed a physician's order dated 10/9/2024 to clean coccyx area wound with Vashe (an anti-septic cleaner). Apply a collagen dressing with silver into wound and areas of tunneling followed by a Vashe soaked 2x2 dressing. Apply Triad (a cream that is used to absorb moderate levels of wound exudates) to peri wound (surrounding skin of wounds). Apply skin protectant to wound edges followed by a sacral bordered foam dressing and change daily. During a surveyor observation of the coccyx wound dressing on 10/23/2024 at approximately 11:00 AM with Licensed Practical Nurse, (LPN), Staff E, she failed to change her soiled gloves and perform hand hygiene between cleaning the wound and before placing the collagen dressing with silver into the resident's wound. During a surveyor interview with Staff E immediately following the above observation, she acknowledged she did not change her gloves and/or perform hand hygiene after cleaning the wound and before placing the collagen dressing with silver into the resident's wound. 1b. Record review revealed Resident ID #153 was readmitted to the facility in January of 2024 with diagnoses including, but not limited to, type 1 diabetes mellitus and hemiplegia (a symptom that involves one-sided paralysis) affecting left non-dominant side. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed a physician's order dated 10/23/2024 to cleanse the left heel with normal saline followed by betadine twice daily. During a surveyor observation of the left heel treatment on 10/23/2024 at 11:26 AM with Staff E, she failed to change her soiled gloves and perform hand hygiene between cleaning the wound with normal saline and prior to the application of the betadine to the wound. During a surveyor interview with Staff E following the above observation, she acknowledged that she failed to change her soiled gloves and perform hand hygiene between cleaning the wound with normal saline and prior to the application of the betadine to the wound. 1c. Record review revealed Resident ID #162 was readmitted to the facility in June of 2024 with a diagnosis including, but not limited to, cellulitis (skin infection). Record review revealed a physician's order dated 9/17/2024 to cleanse wounds on T-spine proximal, distal (upper back), and right scapula with normal saline followed by calcium alginate, extra protective cream to surrounding skin of the wound followed by a large foam dressing daily. During a surveyor observation of the dressing change on 10/23/2024 at 9:36 AM with LPN Staff H, the following was observed: - Staff H placed the resident's soiled dressing on top of his/her bed instead of discarding it in the trash. - Staff H used his index finger to put a medication into the resident's wound and failed to use an applicator. - Staff H failed to remove his soiled gloves and perform hand hygiene after completing the resident's dressing change then proceeded to touch multiple items in the resident's room including the call light and the bed remote. During a surveyor interview on 10/23/2024 at 9:52 AM with Staff H , he acknowledged that he failed to change his soiled gloves and perform hand hygiene prior to touching the above mentioned items in the resident's room, failed to use an applicator to apply the medication to the resident's wound, and placed the visibly soiled dressing on the residents bed. During a surveyor interview on 10/23/2024 at 11:56 AM with the Director of Nursing Services (DNS), she revealed that she would expect the nurses to follow infection control guidelines and remove their dirty gloves and perform hand hygiene before touching multiple items in the room. 2. Review of the Centers for Medicare and Medicaid Services memorandum dated 3/20/2024 with a subject of Enhanced Barrier Precautions in Nursing Homes to Prevent Spread of MDROs states in part, .EBP are indicated for residents with any of the following: .Wounds .even if the resident is not known to be infected or colonized with MDRO .Has a wound .and secretions or excretions that are unable to be covered and contained and are not known to be infected or colonized with any MDRO . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy dated 3/27/2024 titled Enhanced Barrier Precautions Policy and Procedure states in part .Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition .High-contact resident activities include .Wound care: any skin opening requiring a dressing . 2a. Record review for Resident ID #77 revealed s/he has a pressure ulcer to his/her sacrum with current treatment orders. During a surveyor observation on 10/22/2024 at 9:44 AM revealed the facility failed to place Resident ID #77 on EBP precautions. During a surveyor observation on 10/23/2024 at approximately 11:00 AM, LPN Staff E, and Certified Medication Technician (CMT) Staff G failed to wear protective gowns during the coccyx dressing change. During a surveyor interview on 10/23/2024 at approximately 11:20 AM with Staff E, she revealed that she was unaware that the resident was supposed to be on EBP and/or that she needed to wear a protective gown during the resident's coccyx wound dressing change. 2b. Record review revealed Resident ID #146 was readmitted to the facility in February of 2024 with a diagnosis including, but is not limited to, pressure-induced deep tissue damage of right heel. Record review of a physician's order dated 10/16/2024 states in part, . to cleanse right heel wound with normal saline, pat dry, apply nickel thick Santyl (a medication that removes dead tissue from wounds) followed by a calcium alginate dressing (wound dressing that absorbs moisture and promotes healing), cover with ABD (absorbent dressing), and wrap with Kling. Surveyor observations made on 10/21/2024 at 9:14 AM and 1:30 PM, and on 10/23/2024 at 12:04 PM, failed to reveal evidence that the resident was placed on EBP. During a surveyor interview on 10/23/2024 at 12:06 PM with Staff E, she revealed that she was unaware that Resident ID #146 was supposed to be placed on EBP. During a surveyor interview on 10/24/2024 at 11:16 AM with the Infection Preventionist, she acknowledged that both Resident ID #s 77 and 146 had open wounds and should have been placed on EBP. 47939