### HEBERT HEALTH\*CENTER

A Nursing and Rehabilitation Center

An American Senior Living Community

January 25, 2012

Arthur Pullano
Department of Health
Facilities Regulation
3 Capitol Hill
Providence, RI 02908

JAN 25 2012

Dear Arthur,

Enclosed is our completed 2567 for your review from an inspection conducted by your team on 12/19/2011 with an exit on 12/22/2011 and a continuation revisit on 1/6/2012.

Should you have any questions please give me a call.

Sincerely,

Alan J. Barroso RN, BS, ALRA, NHA

180 Log Road, Smithfield, RI 02917-1518 PHONE: 401-231-7016, FAX: 410-231-6149

www.aslci.com

PRINTED: 01/13/2012 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA		FIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.510 (0.11)			A. BUILDII	NG	,	c
		415049	B. WING_		01/09/2012	
NAME OF F	ROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE		
HEBERT	NURSING HOME		1	180 LOG ROAD SMITHFIELD, RI 02917		
	CHANAGOVETA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORREC	TION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 224 SS=K	A Complaint Invest at this facility. An e conducted. State a cited along with Sul Care/Immediate Je-483.13(c) PROHIBI MISTREATMENT/N  The facility must de policies and proced mistreatment, negle and misappropriation.  This REQUIREMENT by: Based on record reinterviews, it was deensure that resident of 12 sample reside. Findings are as follows.  1. Resident ID #1 won 1/31/2011. She it 8/31/2007 and has review of the 10/13/ Set reveals a BIMS Status) score of 4 o cognitive impairment.	igation survey was conducted xtended survey was nd Federal deficiencies were estandard Quality of opardy.  T NEGLECT/MISAPPROPRIAT  velop and implement written ures that prohibit ect, and abuse of residents on of resident property.  AT is not met as evidenced eview, family and staff etermined the facility failed to its are free from neglect for 2 ents [ID#(s) 1 and 7].	F 000	The filing of the plan of correction constitute an admission that the alleged did in fact exist or that is statements or facts cited occurred; POC is filed as evidence of the commitment to quality resident occumpliance with State and Federal if The facility reserves the right to old legal proceedings the alleged deficient as the alleged statements, findings conclusions that form the base allegations.  F224 With regard to resident ID #1:  a) Resident's daughters have not be facility since 12/1/2011.  b) All staff was reeducated as to the of abuse, neglect and mistreatment reporting timeframes and procedure was completed in full on 12/27/2011. c) All staff identified as reporting all abuse outside the required time was verbally and in writing. This task was on 12/29/2011.  d) A Supervisor-to-Administrator reporting and a supervisor-to-Administrator reporting times.	deficiencies any of the rather this he facility's hare in full Regulations. Hallenge by holes as well as of the definitions as well as s. This task legations of s counseled as complete ort has been Each shift duty while or reportable ministrative termine if a nivestigation	12/27/1
	alleged abuse by fa accounts by staff (n	tion attached to a complaint of mily revealed numerous ursing assistants and nurses)	NATHER 8	ensure ongoing compliance.		(X6) DATE
ABORATORY	' DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE **	TH LE ,		(VP) DATE

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.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		415049	A. BUILDIN B. WING		l .	C 9/2012
	ROVIDER OR SUPPLIER NURSING HOME		1	REET ADDRESS, CITY, STATE, ZIP CODE 80 LOG ROAD 6MITHFIELD, RI 02917	0170	9/20 12
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	reporting concerns considered to be in inspection of the resof her daughters. The "Journal Entries" with Alliance for Bett an Incident Report at the local police depastatements by wither All above staff reportincidents to their supplication of Nurses at A review of nurses.  A review of nurses.  1. On 8/10 and 9/13 daughter(s) inspected.  2. On 10/16/2011 the outher medications medication cup from medications into the supplications. The nurse in charge removed food from "You are going to ge has been happening indicated the "daughter's genital area.  4. On 11/24/2011, 9 readmission from the 3-inch, deep purple upper forearm "Fa said that bruise happening indicated that bruise happening and that bruise happening in the said that bruise happenin	regarding what they appropriate touching and sident's private areas by both his information included itten by a representative from er Long Term Care (Alliance), and Witness Statements from artment and written esses.  Ited they had reported these pervisors, including the and the Administrator.  Inotes revealed the following:  /2011 the resident's ed her peri (genital) area.  e resident choked and spit when her daughter took the arthe nurse and put the resident's mouth.  nursing assistant informed that the resident's daughter her mother's tray stating, et too fat, Mom" and that this process more there was seen inspecting her	F 224	With regard to Resident ID #7:  The facility disputes any suggestion alleged deficiency constituted jeopardy as to resident ID #7, December 22, 2011 or at January 9, 20 "This resident was not identified to th incorporated within this IJ tag until 2012."  a) Resident left the facility on 1/9/20 that date, the area on the bunion, podiatrist had healed and staff was protective dressing.  b) Each resident in the facility was a the need for podiatry services. This was completed on 1/8/2012.  c) A new procedure was impler 1/6/2012 to ensure that all resumples assessed for and offered podiatric seafter admission and based on preferenced, to be placed on podiatry list if manage an acute problem or routine in the offer to shower as scheduled is a the charge nurse. Charge nurse will the reasons for refusal and exploral alternatives. Supervisory staff in the supervisory staff in the supervisory staff in the charge nurse of the charge nurse of the charge nurse in the charge nurse of the charge nurse will the reasons for refusal and exploral ternatives.	immediate either at 012.  e facility as January 9, 012. As of scraped by applying a ssessed for assessment mented on idents are rvices soon erence and for visits to nail care who refuses reported to idetermine e potential will review sure that the checks were elem during ember have procedure.	1/8/12
1	notea this bruise prid	or to today - cont (continue) to				

		H AND HUMAN SERVICES				FORM.	01/13/2012 APPROVED 0938-0391
STATEMENT	RS FOR MEDICARE FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mi		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
-		415049	B. WING			C 01/09/2012	
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
HEBERT	NURSING HOME				30 LOG ROAD MITHFIELD, RI 02917		
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F 224	Continued From pa	age 2	F 2	224	Licensed nursing staff was reeducate expectations and procedures for comchecks weekly. This education of 1/12/2012. All nurses not in attendi	pleting skin ccurred on	
	Smithfield Police D allegation of abuse Nursing Assistant ( witnessing the residueds underneath area of her genitals that in September 2 daughter spread her right index finger in another occasion, 1 daughter "spread her her anus". On 11/2	tness Statement from the repartment relative to the revealed that on 12/2/2011 a (NA) [employee I] told police of dent's daughters with their the resident's blanket in the s. Additionally, the NA reported 2011, she witnessed one er mother's labia and insert her ato the resident's vagina. On the NA witnessed the other ner mother's cheeks and rub 4/2011, the NA witnessed a a finger into her mother's		THE PARTY OF THE P	meeting are being reeducated supervisors with this task com 1/20/2012.  d) Weekly skin checks conducted nurses will be monitored by super with spot checks conducted random accuracy. These QI audits (spot check part of our ongoing QI program; reshared with the QI committee.	by shift helpleted by by charge evisory staff ly to ensure eks) will be a	1/20/12
	blue line when the daughters put their brief to see if she v The NA further tolo	y uses briefs which show a brief is wet, the NA saw both hands down their mother's was wet on several occasions. If police that she reported all of the nurses in charge and R).		Andread and the second and the secon			
	that 2 NA(s) [emplo	Vitness Statements revealed byees I and E] also witnessed out "No" and "Stop it" when with the resident.					
	Although the facility	y was made aware of the					

reported by staff.

above alleged incidents, the facility neglected to conduct any investigations and allowed the daughters to visit their mother twice daily without ever assessing or monitoring these visits in order to determine the validity of these allegations

#### PRINTED: 01/13/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 415049 01/09/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 180 LOG ROAD HEBERT NURSING HOME SMITHFIELD, RI 02917 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 224 Continued From page 3 F 224 When interviewed separately by the surveyor on 12/20/2011 at 12:30 PM and 12:45 PM, the Director of Nurses (DNS) and Administrator respectively revealed that in addition to the previously reported allegations, the Alliance had contacted the DNS on 11/21/2011 regarding an anonymous complaint regarding the resident's daughter being observed with her head under the resident's blanket close to the resident's "bottom". Additionally, the complainant alleged that the daughters have been seen touching the resident in her genital area and then smelling their fingers. The DNS and Administrator revealed that they met with the daughters on 11/21/2011 and discussed the allegations in the complaint. They further stated they met with staff on 11/23/2011 after staff reported additional information of alleged inappropriate touching by the daughters and again on 11/30/2011 when a NA (employee I) reported observing the resident's daughters spreading the resident's labia and running their fingers down and into the resident's vagina on 11/23/2011. Although the NA did not report the 11/23/2011 incident timely, the DNS was unable to provide evidence the NA had been counseled or

re-educated.

Additionally, when the Administrator was interviewed on 12/21/2011 at 11:00 AM he revealed he had met with the daughters

buttock areas to check for wetness.

sometime in March 2011 to discuss staff reports that they were touching the resident's peri and

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
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F 224	to not continue with unable to provide a the above-alleged i resident by any modaughters.  When interviewed the social worker (\$11/23/2011 meeting specific in reporting continuing to touch opening her labia to reported observing hand in the resident heads under the sharea and buttocks, evidence of any invincidents. Additional evidence of any systemident.  When questioned or regarding the incidentating the pills from DNS revealed she on 11/13/2011 when chart. When asked the family, the DNS spoken to the nurse had not spoken to the nurse had already happer.  When asked what splace to protect the that the facility has	nistrator advised the daughters in these behaviors, he was my evidence of investigation of incidents and of protecting the nitoring and supervision of the on 12/21/2011 at 12:45 PM, SW) who attended the gronfirmed that the staff was grother the resident's peri area and of see if it was wet. Staff also the daughters putting their t's brief and putting their teets near the resident's peri The SW could not provide estigation of the alleged ally, she could not provide estem in place to protect the on 12/21/2011 at 1:45 PM ent of the resident's daughter at the nurse on 10/16/2011, the became aware of the incident in reviewing the resident's if she spoke to the nurse or is revealed she had only enabout timely reporting but the family because the incident	F.2	224			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BU		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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F 224	When interviewed of NA (employee K) we resident revealed the observed the resident vagina or anus and up to the NA's face smelled clean.  Although the NA condates, she revealed happened as long a she reported both in charge.  The surveyor condut/10/2011 at 3:50 P who is the 3-11 PM supervisor revealed the above allegation perhaps as long ago allegations were rep NA(s) and nurses we resident, which inclusive are NA(s) and eare nurses.  Additionally, she with checking the resider saying: "No, no, it hull "I'm doing this for you supervisor could not revealed that she re DNS just as she had	on 12/21/2011 at 2:20 PM, a ho has provided care to the lat on 2 occasions she ent's daughters putting their it's brief between the brief and then trying to put their hand and asking if their hands and asking if their hands wild not recall the specific that these incidents go as June or July 2011 and ecidents to the nurse in terview on M with an RN (employee F) supervisor. The RN that she was made aware of its over a period of time, of as July 2010. The eorted to her by virtually all the ho provided care for the ended employees E, I, K and S employees J, Q and R who the seed one daughter int's peri area and the resident urts." The daughter replied:	F:	224			

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F 224	The RN supervisor DNS responded by being held with the situation was being RN supervisor aski be placed on the fathe facility could no with or providing care.  Although the RN suand other staff were action by the DNS arevealed that she nallegations to the DAITHOUGH TO THE SUPERVISOR WERE AWARD AND TO THE SUPERVISOR WERE AWARD AND TO THE SUPERVISOR WERE AWARD TO	continued to reveal that the saying that meetings were daughters and that the handled. In response to the ng about what limitation could mily, the DNS responded that t prohibit them from interfering are to their mother.  Ipervisor revealed that she every frustrated by the lack of and Administrator, she eglected to report any of the epartment of Health.  Inistrator, DNS, SW and RN rare of these allegations as 1 the facility failed to provide of the step of the second provided to the (30/2011 when, on the advice facility invoked a "No ainst the daughters and	F	224			
	2/18/2011 with a did Depression. A revi quarterly Minimum (Brief Interview for of 15 indicating sev resident is occasion staff assistance for staff for bathing and A review of the resi reveals intervention resident allows, end	was admitted to the facility on agnosis of Dementia and ew of the resident's 11/2/2011 Data Set reveals a BIMS Mental Status) score of 5 out ere cognitive impairment. The nally incontinent and needs toileting, and is dependent on dipersonal hygiene.  dent's "ADL Deficit Care Plan" as to assist with bathing as the courage her to shower on her ionitor her refusals as well as					

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F 224	A review of informal by the resident's farevealed an allegat received foot care so 2/18/2011. Addition resident had a stroibathed in days.  Review of the resident had a stroibathed in days.  Review of the resident had a stroibathed in days.  Review of the residence of the resident had a stroibathed in days.  Review of the residence of the resident had a stroibathed in days.  Review of the resident with no areas of conskin check identifies subsequent weekly 12/31/2011 continuation.  Furthermore, review Log for this resident was to have shower logs from February be produced by the shower logs from A revealed that 2 resishower over a 4-medocumentation.  Additionally, the fart transported the residence of the resident had a stroibathed had a stroibathed the resident had a stroibathed	ation attached to a complaint mily of alleged neglect from the resident had not since her admission on wally, the family alleged the region of like she had not been sent's Treatment Administration (2011 through 11/5/2011 esident had skin checks weekly incern noted. The 11/12/2011 d long overgrown toenails. The skin checks from 11/19 to e to document no areas of the resident had seen a (2011 and returned with a mederidement of ulceration as of the right foot.  We of the facility's Daily Shower through July 2011 could not facility. A review of the sugust 2011 through 1/9/2012 dent refusals to have a conth period was the only mily arranged for and their concerns about the	F 224			

Facility ID: 415049

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		415049	B. WIN	1G			) 9/2012
- "	PROVIDER OR SUPPLIER NURSING HOME			18	EET ADDRESS, CITY, STATE, ZIP CODE 80 LOG ROAD MITHFIELD, RI 02917		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 224	Office Note with the PM. The podiatrisi long-term patient for revealed that the reher feet cared for it diagnoses of Perip and a chronic buninail care every 3-4. The podiatrist's not "Examination of he neglected feet with long that they have surrounding skin at toes she has deat the bunion area the appearance is month probably lor. Surveyor interview 1/9/2012 at 10:15 A resident's admission be providing care for When the family samother's feet and the 12/24/2011, they readdressing foot call was surprised by the condition of help approximately 8 we Additionally, the dallong as she could in have a chronic buning the state of the providing that the same surprised by the condition of help approximately 8 we Additionally, the dallong as she could in have a chronic buning the same surprised but the condition of help approximately 8 we are could in the provided that t	te podiatrist on 1/6/2012 at 1:00 to revealed the resident was a rom 2007 to 2010. He further esident appeared to not have in some time. The resident's heral Vascular Disease (PVD) on required podiatry visits for months.  The continues to say, in toes shows severely dystrophic elongated nails so begun and pinching on the indithe skin of the neighboring veloped a grade 1 ulceration on the right foot Based on likely been present for over a ager"  With the resident's daughter on AM revealed that, since the on, she expected the facility to or her mother's feet and toes. Aw the condition of their oes during a visit on ealized that the facility was not re. She added that the family ne condition of the resident's brought their concerns about	F:	224			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2)-MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	NURSING HOME		1	REET ADDRESS, CITY, STATE, ZIP CODE 80 LOG ROAD MITHFIELD, RI 02917		
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F 225 SS=K	When interviewed of Director of Nurses (evidence the reside that routine foot car 483.13(c)(1)(ii)-(iii), INVESTIGATE/REF ALLEGATIONS/INDIFF The facility must no been found guilty of mistreating resident had a finding enterer registry concerning of residents or mistand report any know court of law against indicate unfitness foother facility staff to or licensing authorit. The facility must en involving mistreatm including injuries of misappropriation of immediately to the atoother officials in a through established State survey and certain the facility must haviolations are thoroup revent further pote investigation is in proceedings of all invito the administrator representative and	on 1/9/2012 at 2:00 PM the (DNS) could not produce int was bathed twice weekly or e was provided.  (c)(2) - (4) PORT DIVIDUALS  It employ individuals who have abusing, neglecting, or its by a court of law; or have ad into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wedge it has of actions by a an employee, which would be service as a nurse aide or the State nurse aide registry ites.  Sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law procedures (including to the entification agency).  We evidence that all alleged ughly investigated, and must intial abuse while the rogress.	F 224	Resident ID #1- daughters have not be facility since 12/1/2011.  a) The Director of Nurses is no longer by this facility. The Administrator counseled by the EVP of Operations his responsibility to investigate all and allegations, to protect the reside the conduct of investigations and timely follow-up reporting.  Employees ID: E, I, J and S were coufailure to report in a timely manner. the warnings were reviewed and 12/29/2011.  b) We have reviewed and did not other residents affected by this reportable event that has occu 12/29/2011, inclusive of bruising of injury of unknown origin has been investigated and reported to agencies, in a timely manner. Each events were summarized in a report Department of Health and submitted (5) days of the initial report.  The Administrator and Director of ensure that the reporting procedure be followed for any new reportable experts and the reportable experts and the reportable experts and the reportable experts and the reportable experts and procedure be followed for any new reportable experts.	r employed has been a regarding complaints ents during to ensure unseled for The last of signed on identify any issue. Each urred since r any other a effectively appropriate ch of these port to the diwithin five Nurses will as above will	12/29/1

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F 225	incident, and if the appropriate correct  This REQUIREMENT by: Based on record redetermined the facialleged violations in or abuse, including are reported immediate State Survey and Caccordance with Stresidents, ID #1  The facility also fail prevent further pote investigation is in preport the result of working days of the	within 5 working days of the alleged violation is verified ive action must be taken.  NT is not met as evidenced eview and staff interview it was lity failed to ensure that all evolving mistreatment, neglect, injuries of unknown source diately (within 24 hours) to the certification Agency in ate law for 1 of 12 sample  ed to fully investigate and ential abuse while the rogress for ID #1 and failed to all investigations within 5 incident for ID#(s) 1, 2 and 3.	F2	225	c) A new procedure was implemented on		12/2/11
	1/31/2011 with a did of the 10/13/2011 of reveals a BIMS (Br score of 4 out of 15 impairment. The re	agnosis of Dementia. A review juarterly Minimum Data Set ief Interview for Mental Status) indicating severe cognitive sident is incontinent and is for personal hygiene.			a) "This resident was not identified t as incorporated within this IJ tag unt 2012." Resident ID#2 is stable.  The facility disputes any suggestic alleged deficiency constituted	il January 9, on that this immediate	
	A review of nurses' notes revealed the following:  1. On 8/10 and 9/13/2011 the resident's daughter(s) inspected her peri (genital) area.				jeopardy, either at December 22, January 9, 2012. The facility of deficiency as to this resident at Do 2011. In fact, as noted below, the question had been suspended on the facility became aware of the allegation	2011 or at received no ecember 22, employee in the date the	

FORM CMS-2567(02-99) Previous Versions Obsolete

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,		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	!D PREFI				(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
F 225	2. On 10/16/2011 the out her medications medication cup from medications into the 3. On 11/20/2011 at the nurse in charge removed food from "You are going to ghas been happening indicated the "daug mother's genital are 4. On 11/24/2011, son 11/15/2011 from a 3-inch, deep purpright upper forearm (daughter) said that hospital - no one not cont (continue) to mother lacked any evany investigations, nor implemented and physical contact with When interviewed son 12:30 PM and 12:45 (DNS) and Administicated the representative Long-term care (Allion 11/21/2011 about complaint regarding observed with her holanket close to the Additionally, the condaughters have been some content of the son daughters have been desired in the son of the so	ne resident choked and spit when her daughter took the in the nurse and put the eresident's mouth.  nursing assistant informed that the resident's daughter her mother's tray stating, et too fat, Mom" and that this g more. The entry further her was seen inspecting her ea".  I days following a readmission the hospital, the nurse noted be bruise on the resident's "Family notified - dtr bruise happened in the sted this bruise prior to today - donitor".  I dence the facility conducted reported the above incidents in monitored the daughters in the resident.  The properties of the properties of the properties of the daughters in the resident.  The properties of the properties of the properties of the properties of the daughters in the resident.  The properties of the properties	F2	225	Employee ID: T. was suspended from 11/19/2011 during conduct of the in and is no longer employed by this facil.  With regard to Resident ID #3:  This resident was not identified to the incorporated within this IJ tag until 2012."  The facility disputes any suggestion alleged deficiency constituted jeopardy as to this resident either at 22, 2011 or at January 9, 2012. The harm associated with the report go Department 9 days after the alleged rather than 5 days after the alleged in The nursing assistant ID: A that failed the allegation of inappropriate co counseled on 12/6/2011 as to the impairmely reporting.  Nursing assistant ID: U was suspenfacility learning of the allegation of inactions. An investigation was conduct nursing assistant given permission to work on a different unit.  b) We understand that other resident potentially affected by the issues no survey team; however, at this time widentified any further issues of concerning the concerning that the potential is affected by the issues no survey team; however, at this time widentified any further issues of concerning the properties of the concerning that the properties of the potential is any further issues of concerning the properties of th	e facility as January 9, In that this immediate December ere was no bing to the ed incident cident.  If the this immediate is december ere was no bing to the ed incident cident.  If the this immediate is december ere was no bing to the ed incident cident.  If the this immediate is december to the this could be one th	12/6/11

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A, BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		415049	B. WING			0/2012	
	ROVIDER OR SUPPLIER NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 180 LOG ROAD SMITHFIELD, RI 02917				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF T	ULD BE	(X5) COMPLETION DATE	
F 225	they met with the discussed the alleg Alliance. Additional 11/23/2011 when sinappropriate beha again on 11/30/201 reported observing resident's daughter labia and running the resident's vagina of Although the NA discussed timely, the evidence the NA has re-educated regard neglect and mistres. Additionally, the Additi	inistrator further revealed that aughters on 11/21/2011 and ations in the complaint to the ly, they met with staff on taff reported additional viors by the daughters and 1 when a NA (employee I) reported observing the s spreading the resident's neir fingers down and into the n 11/23/2011.  In not report the 11/23/2011 DNS was unable to provide ad been counseled or ing timely reporting of abuse,	F 225	c) A new procedure was impler December 2, 2011 by which the Ad and/or Director of Nursing must corporate staff; the Director of Clini and/or the EVP/CEO that an allegatic received, the steps taken toward in and resolution and the manner in resident is protected during the in On-going monitoring will be done by of Clinical Services. All documentation will be reviewed for completeness and compliance with guidelines.  The Administrator and Director of ensure that the reporting procedures be followed for any new reportable entered to the complete entered t	Iministrator report to cal Services on has been nivestigation which the vestigation, the Director supporting or content, in reporting Nurses will above will	12/2/11	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		G	COMPLETED C	
		415049	B. WII	۱G		I .	9/2012
	ROVIDER OR SUPPLIER		•	1	REET ADDRESS, CITY, STATE, ZIP CODE 80 LOG ROAD MITHFIELD, RI 02917		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	happened as long she reported both charge.  Although the Admi of these allegation failed to provide exinvestigating or improtect the resident advice of a representation of (R23-17-NF-Appenentation of invoked a "No Treat and called the policy of the above reporting rather 10 days after contacted the facility summary report was 12/8/2011 which with allegations but and 18 days 11/21.  2. An incident of very toward resident on 11/19/2011. A Freport was faxed the which was 7 days and days as required.  When interviewed DNS was unable to results of the invest DOH within 5 days.	ago as June or July 2011 and incidents to the nurse in nistrator and DNS were aware as as early as March 2011 they idence of any reporting, olementation of a plan to tuntil 11/30/2011 when, on the entative of the Alliance for Care, they faxed a Required Reporting idix E) to the Department of Facilities Regulation, (DOH), spass order on the daughters be.  In g was not immediate but as faxed to the DOH on as not within 5 working days of rather 8 days after 11/30/2011 (2011).  In the DOH on 11/25/2011, after 11/19/2011 rather than 5 on 12/22/2011 at 9:45 AM the provide evidence that the tigation were reported to the DOH on 12/22/2011 at 9:45 AM the tigation were reported to the	F.	225			
	o. All moldon of h						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		415049	B. WIN	.G		C 9/2012
	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 180 LOG ROAD SMITHFIELD, RI 02917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 225	(employee U) towar to the DOH on 11/2 Summary Report w 12/1/2011, which w rather than the 5 da When interviewed of DNS was unable to late reporting.	ord resident ID #3 was reported 13/2011. A Facility Incident was faxed to the DOH on as 9 days after 11/23/2011 ays as required.  On 12/21/2011, at 9:45 AM, the provide an explanation for the	F 2		o i	ν.ξ <u>σ</u>
	F 226 SS=K  ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 2	The facility disputes any sug alleged deficiency constitution jeopardy as to residents ID #2 December 22, 2011 or at Januara) Residents ID# 1, 2, and without any untoward effect.	gestion that this uted immediate 2 and 3, either at ry 9, 2012.	Ilvan.	
	by: Based on record redetermined the facility policies and proced mistreatment, negled of 5 sample resident findings are as follows: The facility's policy Prohibition" states: resident from abuse and/or misappropriand to further the general treatment"  D. Identification and actual or suspected.	ect, and abuse of residents for ents (ID #s 1, 2 and 3).		b) We recognize that other affected by the issues noted by however; we have not ident issues at this time.  c) The facility policy that referred to in the 2567 has be revised to reflect actual procedures, which are in command federal regulations. All practices were modified modifications to the writt complete by 1/20/2012. All reeducated about definitions and mistreatment, timeliness protecting the resident during investigation. This education 12/27/2011.	addresses abuse een reviewed and practices and pliance with state though the daily dimmediately, ten policy were ll staff has been of abuse, neglect of reporting and the conduct of an was completed	12/27/11/12/12

Facility ID: 415049

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		415049	B. WIN	1G _			C <b>9/2012</b>
	PROVIDER OR SUPPLIER NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 180 LOG ROAD SMITHFIELD, RI 02917				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 226	Continued From page 15 tears must be reported immediately to the supervisor on duty and an incident report is to be filled out.		F 2	Nursing assistant ID: D who failed the charge nurse on the evening soverheard the comment, was of 12/19/2011 verbally and 12/23/20 in accordance with facility policy.		t, that she nseled on	12/19/11
	initial investigation resident is safe and Obtain statements f appropriate adminis comprehensive inte be carried out Car	immediately to: Begin the . Intervene to ensure that the protected from further harm from witnesses Notify the strative personnel so that a rnal facility investigation can rry out proper staff clude all interventions in the		THE WALESTALL	d) The Administrator is responsible polices are being followed and will allegation reported; appropriate policies will be followed.	eview any	
·	ensure that: The inc and completely filled statements are obta	e responsibility of the Director of Nursing to that: The incident reports are accurately mpletely filled out; personnel and witness ents are obtained timely; the investigation prehensive and documented					
	Administrator to N in writing Submit t	y of the Nursing Home lotify the appropriate agencies he report of allegations and ernal investigation to the th.		The state of the s			
	F. Timelines of inves	stigation					
	reported immediatel Division of Facility R then begin the interr	lations in this policy must be y to the Department of Health Regulation. The facility must hal investigation, which is to prwarded to the Department ays."					
L. B.	1. A review of nurse	es' notes from 8/10 to					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED	
		415049	B. Wil	1G _		01/09	) 9/2012
- "	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 180 LOG ROAD SMITHFIELD, RI 02917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 226	11/14/2011 in the crevealed 3 instance being observed tou (genital) and anal a resident's daughter resulting in the resit the medication, an daughter removing and referring to her discovery of a bruis could not be explain.  There lacked evide incident reports, coreported, developed intervention strateg interventions in the Additionally, there was notified the appropriate of allegations investigation to the accordance with the procedure.	linical record for resident ID #1 es of the resident's daughter(s) ching and inspecting her peri reas, an instance of the giving her mother medication dent choking and spitting out instance of the resident's food from the resident's tray getting too fat, and the se on the resident's arm which ned.  nce the facility completed nducted investigations and/or d, monitored and reassessed ies and included the resident's care plan. vas no evidence the facility riate agencies or submitted the se and the results of the internal Department of Health in e facility's policy and	F:	226			
	resident by her dau facility. When quest AM, the DNS and A provide evidence of reporting prior to 11 of a representative Term Care, the facilities Required Reporting the Department of I Regulation, (DOH).	allegation of abuse toward the ghters was reported to the tioned on 12/22/2011 at 10:00 administrator were unable to any investigation and 1/30/2011 when, on the advice for the Alliance for Better Long lility faxed a "Documentation of the (R23-17-NF-Appendix E) to Health, Division of Facilities					
		11/21/2011 when the Alliance					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) N A. BUI		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
•		415049	B. WII	۱G _		C 01/09/2012	
	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 180 LOG ROAD SMITHFIELD, RI 02917		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRI PREFIX (EACH CORRECTIVE ACTION SI TAG CROSS-REFERENCED TO THE AP DEFICIENCY)		ULD BE	(X5) COMPLETION DATE
F 226	contacted the facili summary report wa 12/8/2011 which w the allegations but and 18 days 11/21, not in accordance procedure.  The DNS and Adm provide evidence the and reassessed in included the interverblan as specified in procedure.  2. An incident of very plan as specified in procedure.  2. An incident of very plan as specified in procedure.  A review of the 11/3 to days a the 5 days specified procedure.  A review of the 11/3 statement and the Statement/Interview revealed the incident immediate on duty but rather.  When questioned to work was not suspended began the investigations.	ty about the allegations. A as faxed to the DOH on as not within 5 working days of rather 8 days after 11/30/2011 /2011. The above timelines are with the facility's policy and inistrator were also unable to ney had developed, monitored rervention strategies and entions in the resident's care in the facility's policy and erbal abuse by a NA (employee ID #2 was reported to the DOH facility Incident Summary to the DOH on 11/25/2011, after 11/19/2011 rather than d in the facility's policy and 22/2011 staff's written 11/22/2011 Facility Witness w Documentation Form ent occurred on 11/18/2011, as (employee D) did not report liately to the nursing supervisor 1 day later on 11/19/2011.  On 12/22/2011 at 9:45 AM, the the alleged perpetrator after the incident on 11/18 and di until 11/19 when the DNS ation.	F				
	I ne DNS was una	ble to provide evidence that the					

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		415049	B. WIN	IG		01/09	9/2012
	PROVIDER OR SUPPLIER NURSING HOME			18	EET ADDRESS, CITY, STATE, ZIP CODE 10 LOG ROAD WITHFIELD, RI 02917		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	Continued From p witness reported to abuse immediately the resident was premoval of the alleresults of the inversion of the alleresults of the inversion of the facility's policy and procedure of the DOH on 11/2 Summary Reports 12/1/2011, which rather than the 5 copolicy and procedure of the DOH on 11/2 Summary Reports 12/1/2011, which rather than the 5 copolicy and procedure of the DOH on 11/2 Summary Reports 12/1/2011, which rather than the 5 copolicy and procedure of the policy mistreatment, negrous 15/483.15(a) DIGNIT INDIVIDUALITY  The facility must promanner and in an enhances each resident was provided to the policy of	age 18 he above allegation of verbal y to the supervisor on duty and protected by the immediate eged perpetrator or that the stigation were reported to the		226		her resident survey team nitor this.  ursing were dent's rights with care by 1/12/2012,	
	by: Based on record determined the fa residents in a mar				about resident's rights with regar interference with care. All were in although we partner with our familie development of care plan and in dec whenever needed, the facility has the limits with any family found to be resident's dignity and how the accomplished. All nurses not in at this meeting are being reeducat	d to family formed that es during the ision making e right to set impeding a at can be tendance at	

Event ID:7N0011

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		415049	B. WING		C 01/09/2012	
•	ROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE 80 LOG ROAD MITHFIELD, RI 02917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG			(X5) COMPLETION DATE
F 241	11 Continued From page 19		F 241	supervisors with this task comp 1/20/2012.	pleted by	1/20/12
	1/31/2011. She has 8/31/2007 and has review of the 10/13 Set reveals a BIMS Status) score of 4 cognitive impairme and is dependent of A review of informal alleged abuse by faccounts by staff (in reporting concerns considered to be in inspection of the reof her daughters. To "Journal Entries" with Alliance for Bet and an Incident Refrom the local policion. A review of nurses 9/13 and 11/20/201	notes revealed that on 8/10, 1 the resident's daughter(s)		d) The Administrator is ultimately responsive ongoing compliance. The Administrator is ultimately responsive on the second will review any allegations to ensure procedures are being followed.	ministrator	
	areas. Additionally, resident's daughter	d/inspecting her peri (genital) the 11/20 note reveals the removes food from her tray getting too fat and that this is ten.				
	12:30 PM and 12:4 (DNS) and Administ that a representative Long-term care (All on 11/21/2011 aboregarding the residual control of the control	separately on 12/20/2011 at 5 PM, the Director of Nurses strator revealed respectively re of the Alliance for Better liance) had contacted the DNS ut an anonymous complaint ent's daughter being observed or the resident's blanket close				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		415049	B. WING		i .	C <b>9/2012</b>
	ROVIDER OR SUPPLIER		18	EET ADDRESS, CITY, STATE, ZIP CODE 80 LOG ROAD MITHFIELD, RI 02917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 241	complainant alleged been seen touching area and then smel. The DNS and Admithey met with the didiscussed the alleg Additionally, they met when staff reported touching and inspect again on 11/30/201 reported observing spreading the reside fingers down and in 11/23/2011.  Additionally, when to interviewed on 12/2 revealed he had me sometime in March that they were touch buttock areas to che Administrator advised continue with this be provide any evidence compliance.  When interviewed of the social worker (Stationally and in the resident opening her labia to reported observing thand in the resident.	ottom". Additionally, the d that the daughters have the resident in her genital	F 241			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUIL	JLTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
•		415049		G	C 01/09/2012	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 180 LOG ROAD SMITHFIELD, RI 02917		·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ARRAGA SECENTIAND TO THE A	SHOULD BE	(X5) COMPLETION DATE
F 241	NA (employee K) we resident revealed the observed the resident vagina or anus and up to the NA's face smelled clean.  The NA further revehappened as long a she reported both in charge.  There lacked any enthe issue of dignity or staff or that the resident revenue.	on 12/21/2011 at 2:20 PM, a who has provided care to the nat on 2 occasions she ent's daughters putting their t's brief between the brief and then trying to put their hand and asking if their hands  ealed that these incidents ago as June or July 2011 and incidents to the nurse in evidence the facility addressed with the resident's daughters resident's dignity was ensured are plan to prevent further	F 2	41		
F 247 SS=D	of the daughters' in as March 2011 they evidence the facility and in an environmenhances each reseast. 15(e)(2) RIGH ROOM/ROOMMATA A resident has the the resident's room changed.  This REQUIREMENT by:	T TO NOTICE BEFORE	F 2	F 247 We are respectfully disputing this  a) Resident ID #7 was admitted The resident was having difficult to the roommate. Resident was opportunity to move to another raccepted the room change and was making this decision. The move the benefit of the resident. This longer at our facility.	on 2/18/2011.  y sleeping due as offered the com. Resident was capable of a was made for	prising.

Event ID:7N0011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		415049	B. WING		C 01/09/2012	
	ROVIDER OR SUPPLIER NURSING HOME		1:	EET ADDRESS, CITY, STATE, ZIP CODE 80 LOG ROAD MITHFIELD, RI 02917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 247	it was determined to prior notice of a roomer resident, ID #7.  Findings are as followed to the clinic revealed she was a 2/18/2011 to South she was transferred. Further record reviewed to the responsible party was 2/19/2011 nurse's revealed that the reand a room change. An interview with the 1/9/2012, at 10:15 of family came into vis 2/19/2011, they we	nat the facility failed to provide im change for 1 sample  ows:  al record of resident ID #7 dmitted to the facility on Unit room 6A. On 2/19/2011 d to North A Unit room 46A. ew revealed that the resident's eas her daughter. A review of so note written at 6:00 AM sident had difficulty sleeping	F 247	<ul> <li>b) There were no other residents af we will continue to monitor this sorder to ensure compliance.</li> <li>c) All room changes in the facility are consideration for the residents. discussion with the resident in adv. moves with the exceptions of emerresident safety. Responsible pontacted when the resident is incommake a decision and/or after a remade a decision to make a move. For parties will be notified according to federal regulations.</li> <li>d) Nursing management and/or So staff will be responsible to ensur compliance. Our findings will be shar QI committee.</li> </ul>	edone with There is ance of all gencies for arties are mpetent to esident has Responsible ostate and cial Service re ongoing	1/20/12
F 250 SS=E	Director of Nurses resident was transfe 2/19/2011, she was that the responsible to the room change 483.15(g)(1) PROV RELATED SOCIAL The facility must preservices to attain or	on 1/9/2012 at 2:00 PM, the revealed that although the erred on the morning of a unable to provide evidence a party had been notified prior st.  ISION OF MEDICALLY SERVICE  Divide medically-related social maintain the highest l, mental, and psychosocial	F 250	F 250  a) Resident ID#1 is stable and this needs are being addressed accordingly b) We have not identified any fur with other residents who may be a those issues identified by the survey to	ther issues	W. C.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) N A. BUI		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		415049	B. WI	۱G	4.14444	i	9/2012
	ROVIDER OR SUPPLIER NURSING HOME		- <b>1</b> -	1:	REET ADDRESS, CITY, STATE, ZIP CODE 80 LOG ROAD SMITHFIELD, RI 02917		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 250	by: Based on record r determined the fac related social servi highest practicable psychosocial well to an allegation of #1. Findings are as fol Resident ID #1 wa 1/31/2011. She ha 8/31/2007 and has review of the 10/13 Set reveals a BIMS Status) score of 4 cognitive impairme and is dependent of A review of informa alleged abuse by faccounts by staff (	NT is not met as evidenced eview and staff interview it was sility failed to provide medically ces to attain or maintain the ephysical, mental, and being of each resident relative abuse by family for resident ID	F:	250 L	c) The social worker was include	d to abuse hess. The put her role during the onally, the of the new ministrator report all staff as well acome and hes will be all Services	1/20/12
	considered to be in inspection of the re- of her daughters. In "Journal Entries" with Alliance for Ber an Incident Report the local police deport statements by with All above staff report many incidents to the statements to the statements to the staff report in the	nappropriate touching and esident's private areas by both This information included written by a representative from the Long Term Care (Alliance), and Witness Statements from partment and written					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		415049	B. WING		C 01/09/2012		
, , , , , , , , , , , , , , , , , , , ,	ROVIDER OR SUPPLIER NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE  180 LOG ROAD  SMITHFIELD, RI 02917				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 323 SS=H	as March 2011.  A review of quarter 5/18, 8/5 and 11/2/documentation of s resident relative to  When interviewed the social worker (\$ staff concerns of the touching the reside contacted the faciliallegation of abuse resident.  When asked wheth to discuss these cosW indicated that it spoken with the dadaughters were difficultied overly involved in the easily directed.  The SW could not investigation of the she could not proviplace to protect the Refer to F224, F22 483.25(h) FREE OI HAZARDS/SUPER.	ly social service notes dated 2011 failed to reveal any ocial services provided to the the above allegations.  In 12/21/2011 at 12:45 PM, SW) revealed being aware of the daughters inappropriate in the before the Alliance by on 11/21/2011 regarding an an by the daughters toward the ser she had met with the family oncerns before 11/21/2011, the he DNS and Administrator had be ughters, however, the ficult to deal with as they were not resident's care and were not alleged incidents. Additionally, de evidence of any system in resident.  25, F226 and F241 FACCIDENT	F 25	F 323  The facility is disputing this deficience duplicative language that begins at 10 of page 28 of 39 and continues throu of 39. This language appeared on page 28 of 39 and continues through the	the bottom igh page 31 ge 26 of 39 and should		
	as is possible; and	each resident receives on and assistance devices to		b) We have since reviewed residents risk to fall and have assured interventions are appropriate a implemented.	care plan		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		415049	B. WING_		C 01/09/2012	
	PROVIDER OR SUPPLIER NURSING HOME		11	REET ADDRESS, CITY, STATE, ZIP CODE 80 LOG ROAD MITHFIELD, RI 02917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323		ge 25 NT . is not met as evidenced	F 323	c) Each resident that is assessed as either due to physical limitation or to understand or recall their limitation care plan to identify the risk. If a fall staff investigates to determine the cafall. An intervention is implemented further falls and is written on the care	he inability tions has a occurs, the ause of the to prevent	
	Based on record re representative for the Term Care (Alliance Nurses), it was dete ensure that each re	eview and interviews with a ne Alliance for Better Long e) and the DNS (Director of ermined the facility failed to sident receives assistance accidents for 1 of 12 sample		Nursing assistant care cards we information regarding interventions the care plan to promote safety to eithey are in place and functioning Charge nurses will monitor place function, reporting any malfunidentified.	added to ensure that g properly. ement and	1/20/12
	revealed an allegati #4 had three falls at emergency room (E stay at the facility. The resident's safety call light and bed/ch according to the plaindicated that on the resident was moved 9/23/2011 because	10/31/2011 complaint on by family that resident ID nd sustained injuries requiring ER) visits within her four month he complainant alleged that measures (grippers socks, hair alarms) were not in place on of care. The complainant advice of the Alliance the do another facility on of concerns for her safety.		d) The nursing management team we QI audits to ensure fall interversappropriate and in place per care properly audit findings will be shared with committee.	ntions are lan. These	
	admitted to the facil Cancer, Hypertensic Atrial Fibrillation, Arin her left eye. A rev Minimum Data Sets cognitive impairmer with her ADL(s) {Ac including bed mobil ambulation. Fall Ris	aled the resident was ity with diagnoses of Stomach on, Congestive Heart Failure, exiety, Anemia and Blindness view of the 5/31 and 8/23/2011 indicated the resident had not and she needed assistance tivities of Daily Living; ity, transferring and sk Assessments dated 5/23, 211 indicated the resident was				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER NURSING HOME			180	ET ADDRESS, CITY, STATE, ZIP CODE D LOG ROAD MITHFIELD, RI 02917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 323	at high risk for falls  A 6/3/2011 Interdisthe resident needed due to poor balance forgetfulness and mobility and transfeurine at times. The resident was at risk anti-depressant and of multiple falls at haddition the resider within reach and st with her ADL(s) as  Further record reviethe resident was for small abrasion to haceration to her right ransported to the efamily met with the the safety measure place. Gripper sock  A 6/21/2011 nurse frequently did not have the sident had period further indicated the encouraged to remand put on the grip  On 8/2/2011, the resident was not tover her right expressions.	ciplinary Care Plan indicated d assistance with her ADL(s) e, poor safety awareness, leeding assistance with bed ers and was incontinent of care plan also indicated the c for falls due to d anti-anxiety use and a history fer prior living facility. In the was to have a call light aff would provide assistance needed.  Bew revealed that on 6/7/2011, and sitting on the floor with a er right shoulder and a small light scalp. The resident was emergency room (ER). The DNS and was assured that is in the care plan would be in as were added to the care plan.  Is note indicated the resident ave her call light within reach e bed or chair. Although, the lis of forgetfulness, the note at the resident was ind staff to attach the call light.	F 3	23			

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		,,,,,	IULTIF ILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		415049	B. Wil	۷G		01/09	)/2012
•	ROVIDER OR SUPPLIER			18	EET ADDRESS, CITY, STATE, ZIP CODE 80 LOG ROAD MITHFIELD, RI 02917		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	indicated the reside place but didn't so replacement batter indicated the reside her neck and a her discouraged that so that more safety polace. Record revial larms were added to increase reside on 8/2/2011.  During a phone in AM, the Alliance regipper socks on, and although the aworking. The Allian DNS.  When questioned DNS revealed she alarms and call be and/or provided to devices to ensure unable to produce implemented and/with these interver	age 27  Is note, written at 8:00 AM lent's personal alarm was in und due to needing ries. The nurse's note also lent now complained of pain in adache and she was she had fallen again.  Inter with the DNS and was told rotocols would be put into lew revealed both bed and chair do to the resident's plan of care int safety after the fall incident derview on 12/22/2011 at 10:15 levealed visiting the resident on sident was lying in bed without without a call light within reach alarm was on, it was not note immediately informed the least was aware the gripper socks, all were not consistently working the resident as assistance the resident's safety. She was a evidence the facility had for monitored staff compliance intions to prevent accidents.	F	323			
	representative for	the Alliance for Better Long ce) and the DNS (Director of					The state of the s

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		415049	B. WIN	G		01/09/2012	
	ROVIDER OR SUPPLIER			180	ET ADDRESS, CITY, STATE, ZIP CODE LOG ROAD ITHFIELD, RI 02917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	Nursing Services), failed to ensure that assistance devices 12 sample resident Findings are as follows:  According to the 10 family alleged that with emergency roof from the falls within facility. The complaresident's safety might and bed/chair according to the plaindicated that on the resident was move 9/23/2011 because Record review revealmitted to the fact Cancer, Hypertens Atrial Fibrillation, A in her left eye. A resident was move 10/23/2011 because Record review revealmitted to the fact Cancer, Hypertens Atrial Fibrillation, A in her left eye. A resident was move 10/23/2011 because 10/23/2	it was determined the facility at each resident receives to prevent accidents for 1 of ts (ID #4).	F 3	23	DEFICIENCY)		
	cognitive impairme with her ADL(s) {Ar including bed mobi ambulation. Fall Ri 5/28, 8/2 and 9/6/2 at high risk for falls the resident neededue to poor balance forgetfulness and remobility and transfer.	ent and she needed assistance ctivities of Daily Living} ility, transferring and sk Assessments dated 5/23, 011 indicated the resident was		-			

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	PROVIDER OR SUPPLIER NURSING HOME	1	11	EET ADDRESS, CITY, STATE, ZIP CODE 80 LOG ROAD MITHFIELD, RI 02917			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	resident was at risk anti-depressant an of multiple falls at haddition the resider within reach and st with her ADL(s) as Further record revithe resident was for small abrasion to haceration to her right transported to the efamily met with the the safety measure place. Gripper sock A 6/21/2011 nurse' frequently did not have she was in the resident had period further indicated the encouraged to remand put on the grip On 8/2/2011, the resident was now the right elebow. The resident hitting her head.  An 8/2/2011 nurse' indicated the resident batter indicated the resident had period further indicated the resident hitting her head.	A for falls due to d anti-anxiety use and a history her prior living facility. In the was to have a call light aff would provide assistance needed.  The weekeeled that on 6/7/2011, und sitting on the floor with a er right shoulder and a small plus scalp. The resident was emergency room (ER). The DNS and was assured that is in the care plan would be in as were added to the care plan.  Is note indicated the resident ave her call light within reach the bed or chair. Although, the last of forgetfulness, the note at the resident was ind staff to attach the call light per socks.  The sident was found on the floor and during rounds at 7:00 AM, oted with a bump and small ye and a skin tear on her right the was sent to the ER due to sente, written at 8:00 AM ent's personal alarm was in	F 323				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
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•	PROVIDER OR SUPPLIER NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODI 180 LOG ROAD SMITHFIELD, RI 02917	=	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE A DEFICIENCY)		HOULD BE	(X5) COMPLETION DATE
F 323	The family again m that more safety pro place. Record revie alarms were added	ge 30 et with the DNS and was told brocols would be put into w revealed both bed and chair to the resident's plan of care t safety after the fall incident	F 3	23		
	During a phone interest AM, the Alliance reversely 21/2011. The resignipper socks on, we and although the all working. The Alliance DNS.  When questioned on DNS revealed she was an and call bell and/or provided to the devices to ensure the unable to produce eximplemented and/or with these intervent 483.25(k) TREATM NEEDS  The facility must emproper treatment and special services: Injections; Parenteral and enterest.	stomy, or ileostomy care;	F 3	F 328  a) Resident ID #7 no longer resides  Resident left the facility on 1/9/20 date, the area on the bunior podiatrist had healed and staff a protective dressing.	012. As of that n, scraped by	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		415049	B. WI	IG		4	/2012
	ROVIDER OR SUPPLIER NURSING HOME			18	EET ADDRESS, CITY, STATE, ZIP CODE 80 LOG ROAD MITHFIELD, RI 02917	-	
(X4) ID PREFIX TAG				PREFIX (EACH CORRECTIVE AT CROSS-REFERENCED T		TION SHOULD BE THE APPROPRIATE	
	Continued From particles of the resident ID #7 was 2/18/2011 with a d Depression. A revealed interview of 15 indicating seresident is occasion staff for bathing and A review of the resident's farevealed an allegareceived foot care 2/18/2011.	age 31  NT is not met as evidenced review, family and staff determined the facility failed to or 1' of 6 sample residents bserved, ID #7.  lows:  s admitted to the facility on iagnosis of Dementia and riew of the resident's 11/2/2011. Data Set reveals a BIMS Mental Status) score of 5 out overe cognitive impairment. The shally incontinent and needs retoileting, and is dependent on and personal hygiene.	TAG		CROSS-REFERENCED TO THE APPER DEFICIENCY)  (b) Each resident in the facility was at the need for podiatry services. This was completed on 1/8/2012.  (c) A new procedure was imples 1/6/2012 to ensure that all reseasessed for and offered podiatric seafter admission and based on prefineed, to be placed on podiatry list manage an acute problem or routine.  Nurses that documented that skin completed without identifying probes the months of November and Decebeen counseled regarding proper. This task was completed by 1/20/12.  Licensed nursing staff was reeducated expectations and procedures for completeds. Weekly. This education of 1/12/2012. All nurses not in attendance meeting are being reeducated supervisors with this task completed supervisors with this task completes skin checks so as to ensure of proper documentation. These audit be shared with the QI committee.	assessed for assessment mented on sidents are ervices soon erence and for visits to nail care. The care dems during ember have procedure. It debout the apleting skin occurred on ance at this by shift apleted by ete random diance with optimal and	//20/j2
	Records (TAR) fro 11/5/2011 reveale checks weekly, whareas of concern r check identified to	m 2/18/2011 through d that the resident had skin nich indicated there were no noted. The 11/12/2011 skin ng overgrown toenails. The y skin checks from 11/19 to			·		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		IPLE CONSTRUCTION  IG	COMPLETED	
		415049	B. WII	۷G _		01/09	)/2012
	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 80 LOG ROAD SMITHFIELD, RI 02917		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ULD BE	(X5) COMPLETION DATE
F 328	12/24/2011 continue concern.  Additionally, the fantransported the resi 12/29/2011 due to the condition of her food. The surveyor review Office Note with the PM. The podiatrist long-term patient for revealed that the reher feet cared for in diagnoses of Periph Onychomycosis (and toenails to thicken, as a chronic bunion nail care every 3-4 of the podiatrist's note "Examination of her neglected feet with long that they have surrounding skin and toes she has devent the bunion area colarge dorsal escharasecondary to an old appearance is likely month probably long. The podiatrist further that the area he removed to the podiatrist further that the area from the blade.	nily arranged for and dent to the podiatrist on heir concerns about the t.  ved the 12/29/2011 Podiatry podiatrist on 1/6/2012 at 1:00 revealed the resident was a pm 2007 to 2010. He further sident appeared to not have some time. The resident's heral Vascular Disease (PVD), fungal infection which causes discolor and disfigure as well required podiatry visits for months.  e continues to say, toes shows severely dystrophic elongated nails so begun and pinching on the d the skin of the neighboring eloped a grade 1 ulceration on the right foot There is a which appears to be er blood blister. Based on the been present for over a	F	328			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII	ULTIPLE CONSTRUCTION  LDING	COMPLE	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 180 LOG ROAD SMITHFIELD, RI 02917	· · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 490 SS=K	resident's admission be providing care for When the family sat mother's feet and to 12/24/2011, they readdressing foot car was surprised by the condition of her approximately 8 we additionally, the dattoenails were proper admission to the fallong as she could repressure blisters, of that area before.  When interviewed to Director of Nurses of the residence the resident at routine foot car 483.75 EFFECTIVE ADMINISTRATION of the fallity must be acceptable if to use its efficiently to attain of practicable physical well-being of each in this REQUIREMENT.	M revealed that, since the n, she expected the facility to or her mother's feet and toes. We the condition of their pes during a visit on alized that the facility was not e. She added that the family e condition of the resident's prought their concerns about feet to the facility eks prior.  Aughter revealed the resident's proughter revealed the resident's proughter revealed that for as emember, her mother did ion but never had any reproduce the produce of the provided.  EVERSIDENT WELL-BEING deministered in a manner that resources effectively and or maintain the highest in mental, and psychosocial		F490  a) We have previously improvement plan througho Correction regarding those re (ID#1, 2, 3, and 7).  As noted in the plan of correct and 226, the facility disputes at this alleged deficiency constitionally as to residents ID#1 December 22, 1011 or at Janual b) There were no additional reduring our improvement improvement processes he recognize the importance of the	ut this Plan of sidents identified tion for tag # 225 by suggestion that ituted immediate 2 and 3 either at ry 9, 2012.  Esidents identified review and owever, we do		

#### PRINTED: 01/13/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING С 415049 01/09/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 180 LOG ROAD **HEBERT NURSING HOME** SMITHFIELD, RI 02917 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES !D (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) c) All staff was reeducated as to the definitions F 490 Continued From page 34 of abuse, neglect and mistreatment as well as in a manner that enabled it to use its resources regarding reporting time frames and procedures. 12/27/1 effectively and maintain the highest practicable This task was completed in full on 12/27/2011.. physical, mental and psychosocial well being of each resident. The Director of Nurses is no longer employed by this facility. The Administrator has been counseled by the EVP of Operations regarding Findings are as follows: his responsibility to investigate all complaints As evidenced by the facility's failure to ensure that residents are free from neglect as referenced and allegations, to protect the residents during in F224 with S/S at the K level and resulting in the the conduct of investigations and to ensure timely follow-up reporting. A new procedure potential for serious harm. was implemented on December 2, 2011 by which the Administrator and/or Director of 2. As evidence by the facility failure to ensure that all alleged violations involving mistreatment, Nursing must report to corporate staff; the Director of Clinical Services and/or the EVP of neglect, or abuse, including injuries of unknown Operations that an allegation has been received, source are reported immediately (within 24 hours) the steps taken toward investigation and to the State Survey and Certification Agency. The resolution and the manner in which the resident facility failed to fully investigate and prevent is protected during the investigation. further potential abuse while the investigation is in progress and failed to report the result of all d) On-going monitoring will be done by the investigations within 5 working days of the Director of Clinical Services. All supporting incident as referenced in F225 with S/S at the K documentation will be reviewed for content, level and resulting in the potential for serious completeness and compliance with reporting harm. guidelines. 3. As evidence by the facility failed to implement its own written policies and procedures that prohibit mistreatment, neglect, and abuse of residents as referenced in F226 with S/S at the K level and resulting in the potential for serious harm.

serious harm.

4. As evidence by the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity as referenced in F241 with S/S at the K level and resulting in the potential for

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F 490 F 501 SS=K	Refer to F224, F22 483.75(i) RESPON DIRECTOR  The facility must de as medical director  The medical director implementation of references	5, F226 and F241 SIBILITIES OF MEDICAL signate a physician to serve	F 490	F 501  a) Although no residents were mentioned in this particular tag, the to 224, 225, 226 and 241 imply residents 1, 2, 3 and 7. To the responses to those alleged deficincorporated herein including our disuggestion that this alleged	e references eference to at end our iencies are isputing any	The state of the s
	This REQUIREMENT by: Based on record rewas determined the assist the facility to medical and clinical affect resident care and coordinate medical areas follows:  1. As evidenced by that residents are from F224 with S/S at potential for serious all alleged violations neglect, or abuse, in source are reported to the State Survey facility failed to fully further potential abuprogress and failed	eview, and staff interviews, it a medical director failed to identify, evaluate and address concerns and issues that medical care, quality care dical care in the facility.  The facility's failure to ensure the facility and resulting in the facility in the facility in the facility in the facility and resulting in the		constituted immediate jeopardy as 2, 3 and 7, either at December 22, January 9, 2012.  b) Although no residents were ment tag, we do recognize the important matter and are responding tappropriately.  c) The Medical Director was poverview of the issues identified on by the Director of Clinical Services. time, the Medical Director has been all actions taken with regard to changes, education, corrective action (development. The Medical Director has been meeting held on 1/18/2012 and a 2567 report was forwarded for horizontal meeting held on 1/18/2012 and a 2567 report was forwarded for horizontal Director coordinates med appropriate, assists the facility evaluate, and address medical concerns and issues that affect reand is involved with facility policies meets other regulatory responsibilities.	ioned in this ance of the timely and arovided an a 12/1/2011, Since that updated on personnel as and policy frector was ort at the QI copy of the ais complete are that the lical care as to identify, and clinical esident care, s, QI/QA and	1/18/12

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 520 SS=K	level and resulting harm.  3. As evidence by its own written poliprohibit mistreatmeresidents as refere level and resulting harm.  4. As evidenced by care for residents in environment that make the K level and reserious harm.  Refer to F224, F22	ced in F225 with S/S at the K in the potential for serious  the facility failure to implement cles and procedures that ent, neglect, and abuse of need in F226 with S/S at the K in the potential for serious  The facility failed to promote in a manner and in an naintains or enhances each is referenced in F241 with S/S resulting in the potential for  15, F226 and F241  MBERS/MEET		520	F520  a) Although no residents were mentioned in this particular tag, the to 224, 225, 226 and 241 imply reresidents 1, 2, 3 and 7. To that responses to those alleged defici incorporated herein including our dissuggestion that this alleged constituted immediate jeopardy as to and 3, either at December 22, 2011 og, 2012.  b) Although no residents were mentitag, we do recognize the importamatter and are responding trappropriately.  c) During the QA Committee Meetital 1/18/2012, all area of concern identices.	references ference to t end our encies are sputing any deficiency residents 2 r at January  oned in this nce of the imely and	Production
	assurance commit nursing services; a facility; and at leas facility's staff.  The quality assess committee meets a issues with respectand assurance act develops and impleaction to correct id	mtain a quality assessment and tee consisting of the director of physician designated by the transfer and assurance at least quarterly to identify to which quality assessment invities are necessary; and ements appropriate plans of centified quality deficiencies.			survey were discussed in detail. All actions already taken outlined to the Goals for future actions established quarterly QA committee meetings which all vendors and committee rusual, however a monthly meeting to ensure that problem identified development, implementation and evaluation are consistently active. Director will be invited to all QA/O but in lieu of attendance, all minute and reviewed.  d) The Administrator is responsible ongoing compliance with the QI Plan Program.	committee.  d. Formal vill continue nembers as will be held ation, plan d follow-up The Medical l meetings, s forwarded e to ensure	1/18/12

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) N A. BUI		TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED C		
		415049	B. Wil	νG_		ŀ	/2012
	ROVIDER OR SUPPLIER NURSING HOME		1		REET ADDRESS, CITY, STATE, ZIP CODE 180 LOG ROAD SMITHFIELD, RI 02917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 520	disclosure of the re except insofar as s compliance of such requirements of the Good faith attempt	ecords of such committee such disclosure is related to the committee with the s section.  s by the committee to identify deficiencies will not be used as	F	520			
	by: Based on review of meetings and staff the facility failed to of action to correct noted during the 7, implementing their for immediate repo	of the Quality Assurance (QA) interview, it was determined implement appropriate plans identified quality deficiencies /19/2011 survey, relative to written policy and procedure orting and the protection of a an abuse allegation.				To the second se	
	7/19/2011 for failu policy and procedu the protection of a allegation, there la developed and impland monitoring of Quality Assurance	y was previously cited on re to implement their written ure for immediate reporting and resident following an abuse cked evidence the facility blemented measurable goals compliance as part of the Program.					
	Administrator and Services were una facility had develo	on 12/22/2011 at 9:30 AM, the the Director of Nursing able to provide evidence the ped and implemented a QA ate to correct the above eficiencies.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED C 01/09/2012		
		415049						
NAME OF PROVIDER OR SUPPLIER  HEBERT NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 180 LOG ROAD SMITHFIELD, RI 02917				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE COMPLETION		
F 520			F	520				
	non-compliance wit 'Rules and Regulat Facilities' they are o	th applicable provisions of the ions for Licensing of Nursing deficiencies under State ounds for licensure sanctions."			·			
					·			

RI Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING C B. WING LTC00767 01/09/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 180 LOG ROAD HEBERT NURSING HOME SMITHFIELD, RI 02917 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) M 320 ORGANIZATION and MANAGEMENT 18.2 M 320 M 320 Transfer Agreements, Contracts a) Residents ID#1, 4 did not suffer any untoward affect. Resident ID#4 is no longer a resident at Designated nursing facility personnel 18.2 our facility. shall complete the "Continuity of Care" form ("Short Form") approved by the Department for b) We have since reviewed other residents who each resident who is discharged to another health may have had a continuity of care form care facility, such as a hospital, or who is generated and did not identify any further issues discharged home with follow-up home care in this regard. required. Said form shall be provided to the receiving facility or agency prior to or upon c) During the nurses meeting held on 1/12/2012, transfer of the resident. the nursing staff was reeducated about the need to retain copies of the state approved Continuity This Requirement is not met as evidenced by: of Care form created when transferring Based upon record review and staff interview it residents. Those nurses not in attendance at the was determined the facility failed to complete the meeting had one-on-one education with shift Department of Health approved continuity of care and/or staff development supervisors form for 2 of 2 residents who were discharged to coordinator. another health care facility [ID#(s) 1 and 4]. d) supervisory staff will monitor retention of a copy of the form. These audit findings will be Findings are as follows: shared with the QI committee. 1. Record review revealed that resident ID #1 was discharged to the hospital on 11/13/2011. There lacked evidence of a state-approved "Continuity of Care" form. When interviewed on 12/22/2011 at 10:00 AM, the Director of Nurses (DNS) was unable to provide evidence the state-approved form was completed and provided to the hospital upon transfer of the resident. 2. Record review revealed that resident ID #4 was discharged to the hospital on 9/7/2011. There lacked evidence of a state-approved "Continuity of Care" form. When interviewed on 1/9/2012 at 2:45 PM, the DNS was unable to provide evidence the state-approved form was completed and provided

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER'S DEPLIER REPRESENTATIVE'S SIGNATURE

Administrator

1/25/12

RI Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 01/09/2012 LTC00767 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 180 LOG ROAD HEBERT NURSING HOME SMITHFIELD, RI 02917 SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) M 320 M 320 Continued From page 1 to the hospital upon transfer of the resident.

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