

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>415076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/19/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>JOHN CLARKE RETIREMENT CENTER THE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 VALLEY ROAD MIDDLETOWN, RI 02842</b>		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The annual Federal Re-certification/Modified State Licensure and Complaint Investigation surveys were conducted at this facility.  Deficiencies relative to the Re-certification survey were identified and noted on the enclosed CMS "Statement of Deficiencies" 2567L and State Form.  The John Clark Retirement Center Nursing facility is in compliance with 42 CFR Part 483.70 (a) life Safety from Fire Requirments for Long Term care Facilities.	F 000			
F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(c)  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review and staff interviews, it has been determined that the facility failed to provide the necessary treatment and services in order to promote healing of a pressure ulcer for 1 of 5 sample	F 314			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

09/10/2016

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.

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F 314	<p>Continued From page 1</p> <p>residents reviewed who currently have pressure ulcer (ID #1).</p> <p>Findings are as follows:</p> <p>National Pressure Ulcer Advisory Panel, published 2014, states in part;</p> <p>"... If sitting in a chair is necessary for individuals with pressure ulcers on the sacrum/coccyx or ischia, limit sitting to three times a day in periods of 60 minutes or less... Consult a seating specialist to prescribe an appropriate seating surface...</p> <p>... Select a support surface that provides enhanced pressure redistribution, shear reduction, and microclimate control for individual with Category/stage III, IV, and unstageable pressure ulcers...</p> <p>... Use alternate pressure seating devices judiciously for individuals with existing pressure ulcers... "</p> <p>Record review revealed resident ID # 1 has severe cognitive impairment related to a diagnosis of advance dementia. He/she does not verbalize needs and requires total assistance with activities of daily living including reposition and transfer.</p> <p>A current care plan updated on 7/14/2016 indicates the resident has a pressure sore on his/her coccyx related to incontinence, variable nutritional intake and immobility. The approach includes "... OOB (out of bed) for short periods of time,... referral to wound Dr (doctor)..."</p>	F 314			

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F 314	<p>Continued From page 2</p> <p>An 8/10/2016 Wound Care Specialist Evaluation indicates the resident currently has a pressure ulcer on the coccyx that measures approximately 2.0 cc (length) x 0.9 cc (width) x 0.1 (depth) which is characterized as unstageable necrosis (known but not stageable due to coverage of wound bed by slough and/or eschar) with moderate serous (drainage).</p> <p>The periwound radius is characterizes as excoriation, maceration (softening and breaking down of skin), surrounding deep tissue injury (purple /maroon).</p> <p>The recommendation includes "Low air loss mattress (float the patient on air-filled cells while circulating air across the skin to reduce moisture and help maintain a constant skin interface pressure), limit sitting to 60 minutes,..."</p> <p>Surveyor observations on 8/17/2016 at 8:15 AM, 9:00 AM, 11:30 AM and 1:30 PM, and on 8/18/2016 at 8:15 AM, 9:00 AM, 11:30 AM and 1:15 PM revealed the resident sitting in his/her wheelchair.</p> <p>Additional observation on 8/19/2016 between 8:05 AM to 9:00 AM revealed the resident sitting in his/her wheelchair. It was noted that the resident has a foam cushion in his/her wheelchair which is approximately 4 inches thick.</p> <p>Observation of the wound with the unit nurse (staff A) on 8/19/2016 at approximately 9:00 AM revealed an unstageable pressure ulcer that measures approximately 2.5 cc (length) x 2.5 cc (with) with necrotic tissue on the wound bed.</p> <p>The skin surrounding the wound is</p>	F 314			

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F 314	<p>Continued From page 3</p> <p>excoriated/macerated. It was noted that the resident has an overlay air mattress on his/her bed (parallel air tubes that can be inflated and deflated on a set schedule).</p> <p>During an interview on 8/18/2016 at 1:45 PM, with the nursing assistant (NA), staff B, who regularly cares for the resident revealed that the resident is assisted out of bed to the wheelchair on the 3rd shift (11:00 PM -7:00 AM) and remains sitting in the wheelchair until approximately 9:00 - 9:30 AM (approximately 150 to 210 minutes).</p> <p>Staff B further stated the resident is in bed after breakfast and again is assisted out of bed to the wheelchair at approximately 11:00 AM to 11:30 AM and remains sitting in the wheelchair until approximately 1:00 - 1:30 PM (approximately 90 minutes to 150 minutes). Staff B confirmed that the resident has a foam cushion while sitting in his/her wheelchair.</p> <p>During a subsequent interview with the unit nurse (staff A) on 8/19/2016 at 9:50 AM, she confirmed the above findings.</p> <p>When questioned during the phone interview on 8/19/2016 at 11:30 AM, the NA, staff C who works on the third shift stated the resident is assisted out of bed to his/her wheelchair between 6:00 AM to 6:30 AM.</p> <p>During an interview with the Assistant Director of Nursing Services (ADNS) on 8/19/2016 at approximately 10:30 AM, she was unable to provide evidence that the physician was informed that there is a new recommendation from the wound doctor. In addition, the ADNS disclosed that there is no recommendation relative to</p>	F 314			

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F 314	Continued From page 4 seating device.  During a subsequent interview on 8/19/2016 at approximately 12:00 PM with the resident's primary physician, he stated he generally accepts the recommendations from the wound doctor and he was not informed of the above recommendations.	F 314			
F 500 SS=D	OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT CFR(s): 483.75(h)  If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h) (2) of this section.  Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it had been determined that the facility has failed to abide by the facility's Physician Services Agreement to inform the resident's primary care physician relative to recommendation by wound	F 500			

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F 500	<p>Continued From page 5 doctor for 1 of 5 sample residents (ID# 1).</p> <p>Findings are as follows:</p> <p>A review of the Physician Services Agreement between the Facility and the Provider (wound doctor) dated 2/11/2015 indicates the facility responsibility is to inform the resident's primary care provider of the clinician's recommendations within 24 hours.</p> <p>Record review revealed resident ID #1 currently has a pressure ulcer on the coccyx which is characterized as unstageable necrosis (known but not stageable due to coverage of wound bed by slough and/or eschar).</p> <p>Further record review revealed an 8/10/2016 Wound Care Specialist Evaluation with recommendations to include "Low air loss mattress, limit sitting to 60 minutes,..." There is no evidence the primary care physician was made aware of the recommendations.</p> <p>During an interview on 8/19/2016 at approximately 12:00 PM, the resident's primary care physician stated he was not informed of the recommendations.</p> <p>When questioned on 8/19/2016 at approximately 2:30 PM, the Director of Nursing Services was unable to produce evidence that the above recommendations were brought to the attention of the physician.</p> <p>You are hereby formally notified that where the above listed deficiencies also constitute non-compliance with applicable provisions of the "Rules and Regulations for Licensing of Nursing</p>	F 500			

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F 500	Continued From page 6 Facilities" they are deficiencies under State Regulations and grounds for licensure sanctions.	F 500			

RI Department of Health

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M 240	<p><b>ORGANIZATION and MANAGEMENT 15.4</b> <b>Handling of Resident Funds</b></p> <p>15.4 In addition to requirements of §15.1 through §15.3 of these Regulations, each nursing facility shall conform to the standards of Medical Assistance Program Uniform Accountability Procedures for Title XIX Resident Personal Needs Funds in Community Facilities and ICF-MR Facilities [Reference 13] in relation to Title XIX Medicaid recipients.</p> <p>This Requirement is not met as evidenced by: Based on a review of the Residents Personal Needs Funds and interview with the Office Manager, it was determined that the facility failed to adhere to Section V of The Uniform Accountability Procedures for Title XIX residents of 5 of 6 resident accounts reviewed that are managed by the facility, sample residents ID #'s 2, 8, and 10 and non- sample residents ID #'s 18 and 19.</p> <p>Finding are as follows:</p> <p>Section V of the Uniform Accountability Procedures (Modified May 2010 states: "Each facility shall obtain upon admission or adoption of these regulations from the resident, guardian, next of kin or person responsible for the resident, a signed and witnessed document indicating the wishes of the resident as to the manner in which personal funds are to be handled..."</p> <p>A review of the authorization documents provided by the facility for sample residents ID #'s 2, 8 and 10 and non-sample residents ID #'s 18 and 19 revealed no current signed and witnessed</p>	M 240		

Facilities Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE <b>09/10/16</b>
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M 240	<p>Continued From page 1</p> <p>statements indicating the wishes of the resident and /or guardian as to the manner in which personal funds are to be handled.</p> <p>On 8/18/2016 at approximately 1:45 PM, the surveyor interviewed the Office Manager concerning the authorization statements. She disclosed that she was unaware that the authorization documents had not been signed and witnessed.</p>	M 240		