STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415076	A. BUILDING _____ B. WING _____	08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHN CLARKE RETIREMENT CENTER THE	600 VALLEY ROAD MIDDLETOWN, RI 02842

(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 Federal Re-certification/Modified State licensure survey were conducted at this facility. Deficiencies were identified and documented on the enclosed CMS "Statement of deficiencies" and State Form. The John Clark Retirement Cntr is in substantial compliance with 42 CFR Part 483.70(a) Life Safety from Fire Requirements for Long Term Care Facilties.	F 000		
F 309 SS=D	. PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.25 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interview, it has been determined that the facility has failed to ensure that each resident receive and the facility provide the necessary care and services to attain or maintain the highest practicable physical well-being in accordance with the comprehensive assessment and plan of care for 1 of 1 sample residents, (Resident ID # 3) relative to risk for aspiration.	F 309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/09/2015

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F 309	Continued From page 1 Findings are as follows: Resident ID #3 has current diagnoses which include dysphagia, aspiration Pneumonia and a seizure disorder. The resident was readmitted to the facility after a hospitalization on 8/6/2015 with a diagnosis of pneumonia secondary to aspiration. Record review includes a 8/6/2015 physicians order for 1:1 feed, upright centered position, small sips and bites. On 8/7/2015 a physician's telephone order states aspiration precautions every shift for aspiration risk. Record review revealed a nursing progress note dated 8/15/2015 that states appetite good, 1:1 feed aspiration precautions. A subsequent note dated 8/16/2015 revealed head of bed elevated and 1:1 feed. The resident had a speech language evaluation on 8/6/2015 that indicates severe oral/pharyngeal dysphagia. A review of resident's ID #3's current care plan has a focus area dated 8/6/2015 that states aspiration pneumonia. On 8/17/2015 at 12:07 PM the resident was observed by the surveyor upright in bed, eating a pureed lunch with the privacy curtain closed, there was no supervision observed. On 8/18/2015 at 8:50 AM the resident was	F 309		

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observed by the surveyor in bed eating independently with no staff supervision. At this time,the head of bed was elevated and the privacy curtain was observed closed.

At 12:00 PM, another surveyor observation of this resident revealed the resident eating lunch alone in his room with the head of bed elevated and the privacy curtain closed..

During an interview with the DNS on 8/20/2015 at 9:45 AM, she stated the resident is supposed to be supervised by the nursing assistant (NA) for meals.

The surveyor interviewed the speech therapist on 8/20/2015 at 12:30 PM. She told the surveyor that the resident did not need the 1 on 1 supervision but does require observations at least 3-4 times while eating. She further stated that she did not think supervision would be adequate if the curtain was closed while the resident was eating as he has a history of aspiration.

The surveyor interviewed the nursing assistant (Staff D) on 8/20/2015 at 1:00 PM who told the surveyor that he checks on the resident during meals, at least every 15-20 minutes. The surveyor asked this nursing assistant why the curtain was closed and he stated that the resident's roommate does not like the bright light from the window.

On 8/21/2015 at 10:00 AM the surveyor interviewed the MDS (Minimum Data Set) nurse regarding the resident's care plan, and questioned if something should be in the care plan regarding the supervision during meals and she was unable to explain why it was not in the

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F 309	Continued From page 3 care plan and added it. A review of resident's ID #3's current care plan on 8/21/2015 revealed an added intervention dated 8/21/2015 which states "supervision with meals". The surveyor interviewed the resident's physician on 8/21/2015 at approximately 11:30 AM, who stated that the resident is " a silent aspirator and that he should have a G-Tube, but that is up to the resident".	F 309		
F 441 SS=E	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.65 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441		

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from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on surveyor observation, record review and staff interview, it was determined the facility failed to ensure a sanitary environment to help prevent the transmission of infections relative to housekeeping, cleaning of glucometers, and the proper disposal of laundry for 2 of 4 sample residents, (ID # 6 and 10) and 1 of 1 non-sample resident ID # 15.

The facilities "Patient Room Disinfection Training Library Workbook" states in part Sec 5b. Isolation Patient Rooms- Daily Cleaning.

"Immediately bag all cloths, wet mop heads, and dust mop heads used in the room as infectious waste. DO NOT use them in any other area. After cleaning the room, decontaminate any equipment that has been visibly soiled such as mop handles, buckets and castors with disinfectant.

Thoroughly rinse out the mop bucket and wringer and replace with clean water and disinfectant

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before cleaning the next area."

1. On 8/18/2015 at 9:16 AM the surveyor observed a housekeeper (Staff B) entering a precautions room of resident ID # 6. Doning gloves but not wearing a gown. She proceeded to enter and clean the toilet with a cloth and spray bottle and then return the spray bottle to the housekeeping cart and placed the cloth in a bin on the housekeeping cart.

With the same gloves she took the wet mop from the bucket of water on the cart and proceeded to enter and mop the floor in the residents room. Upon completion, she replaced the mop into the bucket of water on her cart.

Still wearing the same gloves she took another spray bottle and a cloth and re-entered the resident's room. She wiped off the furniture, bed rails and table tops of both residents in the room. Upon completion, she returned the items to the housekeeping cart and removed her gloves and discarded them and proceed on to the next room to be cleaned.

On 8/18/2015 at 9:25 AM, the surveyor interviewed the housekeeper (Staff B) when she completed the cleaning of the room. She stated that she "did not need to wear the gown as she was not going to touch the resident that only the nursing assistants need to wear the gown".

On 8/20/2015 at approximately 1:00PM the Director of Nurses and the Director of Housekeeping were interviewed. They stated that housekeeping should wear a gown and gloves when cleaning a precautions room. In addition, housekeeping should change cleaning equipment

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after completing a precautions room.

Review of the User's Guide for the Optium EZ glucose monitor states in part: " alcohol is not an approved product for cleaning environmental areas potentially contaminated with bloodborne pathogens. To disinfect glucose meters, use the EPA approved germicidal disinfectant labeled effective against TB or HBV or 1:10 bleach to water concentration solution."

2. On 8/18/2015 at 11:25 AM, the surveyor observed the Nurse (Staff A) use the glucometer to obtain a blood sugar for non-sample resident ID # 15. Staff A cleaned the glucometer with an alcohol wipe before and after obtaining the blood sugar. She then at 11:40 AM used the same glucometer to obtain a blood sugar on resident ID # 10. After completing the blood sugar for resident ID # 10, this nurse cleaned the glucometer with an alcohol wipe.

During the surveyor interview with the Nurse (Staff A) on 8/21/2015 at 9:00 AM, this nurse indicated that she always uses alocohol wipes instead of the Sani Wipes.

During the surveyor interview with the Director of Nursing on 8/19/2015 at 1:30 PM, she stated Sani Cloths are used to clean glucometers.

3) During surveyor observation of the bathing room on the Bath Row unit, on 8/19/2015 at 1:08 PM, two surveyors observed soiled clothing, pants, shirt, brief and a towel that were soiled with fecal material, and were left on a shelf in the bathing room.

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F 441	Continued From page 7 On 8/19/2015 at approximately 1:15 PM, a nursing assistant (Staff C) on the Bath Row Unit, was interviewed. She was unable to explain why the soiled items had not been placed in the laundry bin. "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 Facilities' they are deficiencies under State Regulations and grounds for licensure sanctions."	F 441		

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M 070	ORGANIZATION and MANAGEMENT 11.5 Quality Improvement Program 11.5 The quality improvement committee for a nursing facility shall annually review and approve the quality improvement plan for the nursing facility. Said plan shall be available to the public upon request. This Requirement is not met as evidenced by: Based on a review of the facility's Quality Improvement (QI) Program and staff interview, it was determined the facility failed to annually review and approve the quality improvement plan for the nursing facility. Findings are as follows: During an interview with the Administrator regarding the facility's quality improvement program, on 8/20/2015 at 9:30 AM, she was unable to produce evidence that the plan was reviewed and approved annually by the committee.	M 070		
M 075	ORGANIZATION and MANAGEMENT 11.6 Quality Improvement Program 11.6 Each nursing facility shall establish a written quality improvement plan that shall be reviewed by the Department during the nursing facility ' s annual survey and that includes: (a) program objectives; (b) oversight responsibility (e.g., reports to the governing body, QI records) (c) nursing facility-wide scope; (d) involvement of all resident care	M 075		

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M 075	Continued From page 1 disciplines/services; (e) includes methods to identify, evaluate, and correct identified problems; (f) provides criteria to monitor nursing care and services, including, but not limited to: (1) medication administration; (2) prevention and treatment of decubitus ulcers; (3) dehydration, and nutritional status and weight loss or gain; (4) accidents, injuries and unexpected deaths; (5) changes in mental or psychological status; (6) resident and/or Family Council grievances; (7) plans of correction developed in response to licensing agency 's inspection reports , and (8) any other data appropriate to monitor resident ' s quality of care and quality of life. This Requirement is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to provide a complete written annual quality improvement (QI) plan that included all the required components. Findings are as follows: During a review of the facility's quality improvement plan that was reviewed on 8/20/2015 at approximately 10:00 AM with the administrator, there was no evidence that the QI plan contained the following components: (a) program objectives; (e) includes methods to identify, evaluate, and correct identified problems; (f) provides criteria to monitor nursing care and services, including, but not limited to:	M 075		

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M 075	Continued From page 2 (1) medication administration; (2) prevention and treatment of decubitus ulcers; (g) dehydration, and nutritional status and weight loss or gain; (h) accidents, injuries and unexpected deaths; (i) changes in mental or psychological status; (j) resident and/or Family Council grievances; (k) plans of correction developed in response to licensing agency 's inspection reports , and (l.) any other data appropriate to monitor resident ' s quality of care and quality of life. The surveyor interviewed the Assistant Director of Nurses and the Director of Nurses on 8/20/2015 at approximately 2:00 PM. they could not produce any evidence that the aforementioned components were addressed .	M 075		
M 590	RESIDENT CARE SERVICES 21.1 Resident Care Policies Section 21.0 Resident Care Policies 21.1 Each nursing facility shall have written resident care policies to govern the continuing nursing care and related medical or other services provided. 21.1.1 Care practices shall be person-centered in their implementation and resident-directed in their development whenever possible, and 21.1.2 The nursing shall provide care and services to all residents in accordance with the prevailing community standard of care.	M 590		

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M 590	Continued From page 3 This Requirement is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to adhere to it's policy and procedure for weights and notification of physician and consultant dietician for 2 out of 13 sample residents, ID #'s 1 and 5. Findings are as follows: The facility's Height and Weight Policy and Procedure states in part : " Any resident with a weight change of + or - 3 pounds or more in one week or + or - 5 pounds or more in one month will be reweighed within 24 hours. RN will document reweigh in the residents' records, document any pertinent information in the residents'records"'weight change note" and notify RD (Registered Dietician) and MD (Medical Doctor) as appropriate". 1) A review of the documented weights for ID#1 revealed the following : On 12/1/2014, this resident's weight was 149.4 pounds but on 12/5/2015 the weight was 144.6 pound, a 5.2 pound weight change; On 1/12/2015, this resident's weight was 158.0 pounds but on 1/19/2015 the weight was 152.8 pounds, a 5.2 pound weight change. On 4/13/2015 , this resident's weight was 152.0 pounds but on 5/2/2015 the weight was 147.6 pounds, a 4.4 pound weight change. There lacked evidence that the resident was reweighed on the aforementioned dates. In	M 590		

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M 590	Continued From page 4 addition, the resident's physician nor consultant dietician were informed of the weight changes. On 1/29/2015, this resident's weight was 154.4 pounds but on 2/2/2015 the weight was 148.2 pounds, a 4.4 weight change. There lacked evidence that this resident's physician nor consultant dietician were informed of the change. 2) A review of the documented weights for sample resident's ID # 5 revealed the following: On 2/19/2015, this resident's weight was 144.5 pounds but on 2/23//2015 the weight was139.0 pounds, a 5.5 pound weight change; On 3/16/2015, this resident's weight was 133.8 pounds but on 3/23/2015 the weight was 130.8 pounds, a 3 pound weight change. There lacked evidence that the resident was reweighed on the aforementioned dates. On 8/5/2015, this resident's weight was 122.8 pounds but on 8/10/2015, the weight was 117.0 pounds, a 5.8 pound weight loss. There lacked evidence that this resident's physician nor consultant dietician were informed of the weight changes. On 8/21/2015 at approvximately 11:30 AM, the Director of Nursing and the MDS Co-ordinator were interviewed. They were unable to produce evidence relative to the reweighing of the residents nor notification of physicians or consultant dietician.	M 590		