RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01518	A. BUILDING: _____ B. WING _____	C 10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA VILLA ASSISTED LIVING	336 WILLETT AVENUE RIVERSIDE, RI 02915

(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) COMPLETE DATE
S 003	Initial Comments An unannounced complaint/incident investigation survey, ACTS reference numbers 101837, was conducted at this residence on 10/8/2025 to determine compliance with state regulations. A deficiency was identified as a result of this survey.	S 003	I. Administrator will develop a new policy regarding administration of medications . The policy aims to prevent or avoid medication errors that can arise from received new orders from the resident's provider and ensure that medications are administered as ordered Policy and Procedure will entail the following steps:	10/30/2025
S 565	Residential Care Services 2.4.24.B.1 Medication Services 2.4.24 (B) (1) Administration of Medications 1. Residences licensed at the M1 level may administer medications to residents including, but not limited to, removing medication containers from storage, assisting with the removal of a medication from a container for residents with disability which prevents independence in this act, and/or administering the medication directly to the resident. a. The resident or guardian must provide written authorization for the residence to provide administration of medications. b. Medications shall be administered in accordance with written orders of a physician. The residence must provide in writing, a description of services provided by the residence to each physician, including limitations on service. c. All medications must be checked against a physician's orders by a licensed nurse, or pharmacist. d. The resident must be identified prior to administration of any medication.	S 565	1. Daily check of Q-Mar updates will be done by Q-Mar app. administrator of Bella Villa- (by Administrator or designated staff.) Q-mar updates will be communicated to staff on duty. 2. Staff is instructed to be alert to new faxed orders from Pharmacy and Provider. Staff on duty will report to RN/administrator all newly received faxed orders. Staff will file received orders in book for "New Orders". The new orders will be passed onto staff coming for next shift during end of shift reporting. (By staff on duty after conferring with administrator about new faxed orders) 3. New faxed orders will be cross checked with the Q-mar updates reported from computer (will be done by facility administrator). Any faxed order that is received by staff which does not appear in Q-Mar will be sent to Pharmacy for updating of Q-Mar. 4. Any discontinued medication/s will be removed from all medication packets/ medication bin with supervision of RN. Follow-up with pharmacy via phone call/fax or email will be done for delivery of new prescriptions. (By staff on duty or RN) 5. Any questions or concerns on the Q-mar by staff on duty on a resident's medications must be communicated to Administrator prior to administration of medications for a particular resident. 6. All new orders filed in the book for new orders will be reviewed by RN and then filed in the resident's chart. II. Inservice regarding the new policy will be done and communicated to all staff.	11/04/2025

10/31/25

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

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S 565	Continued From page 1 e. The medication must be in the original pharmacy-dispensed container with proper label and directions attached and be administered in accordance with such label. f. Injectable medications, including but not limited to insulin, which cannot be self-administered by the resident, must be administered by a licensed nurse. g. There shall be written a policy/procedure for the disposal of hypodermic needles, syringes and other such instruments that is in compliance with rules and regulations governing Hypodermic Needles, Syringes & Other Such Instruments (Part 20-15-6 of this Title). (1) The legal destruction of hypodermic needles, syringes or other such instruments is the responsibility of the last entitled or authorized possessor. (AA) All personnel or residents legally authorized to use disposal syringes and needles, shall destroy them after one (1) use. (BB) Excess and undesired needles, syringes and other such instruments shall be stored in impervious, rigid, puncture- resistant container for disposal. Intact needles shall be placed directly into the collection containers. (CC) Personnel handling disposal waste materials such as needles, syringes, and other such instruments may treat and destroy such waste by a DEM-approved alternative treatment/destruction technology or prepare the regulated medical waste for off-site transport by a DEM-permitted medical waste transporter.	S 565		

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S 565	Continued From page 2 h. Individual medication records must be retained for each resident to whom medications are being administered and each dose administered to the resident must be properly recorded. i. Any medication administered by the residence and refused by a resident shall be documented and reported, as appropriate. j. Medications shall be stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access. Provisions for safe storage may include lockable containers, secure spaces, or lockable units, as appropriate to the residence and the resident population. k. All medication in the residence, regardless of whether controlled by employees or by the resident, shall be stored securely as stated in § 2.4.24(A)(3)(a)(8) of this Part. l. All centrally stored medications shall be maintained in accordance with manufacturer's labeling and administered by authorized personnel. This Requirement is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the residence failed to provide care and services in accordance with prevailing community standards of care relative to following a physician's order for one of three residents	S 565		

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S 565	Continued From page 3 reviewed, ID #1. Findings are as follows: Review of a facility report incident, submitted to the Rhode Island Department of Health on 8/6/2025, revealed that Resident ID #1 was administered 60 milligrams (mg) of Baclofen (a medication used to relax muscles) as apposed to the 20 mgs of Baclofen that was ordered. Additionally, ID #1 was sent to the hospital following the incident for evaluation. Review of a facility policy titled, "Administration of Medications" last reviewed on 12/8/2024, states in part, "...Medications shall be administered in accordance with written orders of a physician..." Review of a document titled "Bella Villa Assisted Living" signed by both the Administrator and ID #1, states in part, "...I consent to allowing the appropriately licensed professional staff to administer medication to me on a daily basis. The medication techs and the nursing staff will administer my medications exactly how my doctors have prescribed the medications to me..." Record review revealed ID #1, moved into the facility in May of 2025, with a diagnosis including, but not limited to, leukodystophy (a neurological condition that can affect speaking, walking, vision, hearing, thinking and other neurological functions). Record review revealed a physician's order with a start date of 5/20/2025 and an end date of 7/29/2025 at 9:00 AM, for Baclofen 10 mgs, administer four tablets by mouth four times a day. Record review revealed a physician's order with a	S 565		

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S 565	Continued From page 4 start date of 7/29/2025 at 12:35 PM, for Baclofen 20 milligrams (mgs), one tablet three times a day. Review of a progress note dated 7/31/2025, revealed that Certified Medication Technician (CMT), Staff A, accidentally gave ID #1 the wrong dose of Baclofen. The progress note further revealed that Staff A was confused due to the change in the medication and gave both Baclofen 40 mgs along with Baclofen 20 mgs, indicating that ID #1 received 60 mgs of Baclofen. During a surveyor interview on 10/8/2025 at 10:46 AM with Staff A, she revealed that on 7/31/2025, she administered both medications to the resident, the 40 mgs of Baclofen and the 20 mgs of Baclofen for a total dose of 60 mgs. A surveyor observation on 10/8/2025 at approximately 10:50 AM, with the Administrator, revealed that ID #1's medication is packaged in individual bags, labeled with the time the medication is to be administered, with multiple different medications in the same bag. It further revealed that the medication is dispensed for multiple days at a time, indicating that if a medication change occurred, the original medication could be still in the individual package, mixed in with active medication orders, which could lead to the resident being administered a discontinued medication. During a surveyor interview, immediately following the above-mentioned observation with the Administrator, she revealed that if there was a change in medications, the new medication would be delivered in a separate container and would be administered to the resident as ordered, in addition to the individual bag of medications. She revealed, staff are responsible for removing	S 565		

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S 565	Continued From page 5 discontinued medications from prepackaged bags before administering them. ID #1 would have received 40 mg of Baclofen in a prepackaged bag and 20 mg on a separate card, and it is the responsibility of the CMT or nurse to identify and remove the duplicate. During a surveyor interview on 10/8/2025 at approximately 11:30 AM, with the Administrator, she acknowledged that Staff A, administered the incorrect dose of Baclofen to ID #1. She further revealed that she would expect staff to double check the physician's order to the medication and to notify herself and/or the pharmacy with any discrepancies. Furthermore, she acknowledges that medications are dispensed for multiple days with multiple medications in the same package, and acknowledged the risk of administering a medication that could have been discontinued if the discontinued medication is not noticed and removed.	S 565		