| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | ALR01306 | A. BUILDING: _____ B. WING _____ | C 10/21/2025 |

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| S 003 | Initial Comments<br><br>An unannounced complaint/incident investigation survey, ACTS reference numbers 102255 and 102256, was conducted at this residence on 10/21/2025 to determine compliance with state regulations. A deficiency was identified. | S 003 | S 565 – No resident(s) has been seriously harmed as the result of a medication error. Res ID #1 was evaluated by [redacted] Hospital and [redacted] Neurologist, and no medical treatment was deemed necessary. Staff A received a written Corrective Action warning for [redacted] actions and was counseled by the nurse Manager on correct medication administration procedures. The Nurse Manager has been directed to closely monitor Staff A's performance. The Office Manager, who manages all campus scheduling of assisted living employees, has been directed to reduce the number of scheduled hours for Staff A, and to reduce the number of residents Staff A is responsible for in administering medications. Fatigue and lack of familiarity may have been factors contributing to the medication error.<br><br>A specific Medication Error policy and procedure (attached) has been created and disseminated to all staff responsible for medications. The Quality Assurance Committee will continue to investigate and review medication errors for improvement. | 11/05/25 |
| S 565 | Residential Care Services 2.4.24.B.1 Medication Services<br><br>2.4.24 (B) (1) Administration of Medications<br><br>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.<br><br>a. The resident or guardian must provide written authorization for the residence to provide administration of medications.<br><br>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.<br><br>c. All medications must be checked against a physician's orders by a licensed nurse, or pharmacist.<br><br>d. The resident must be identified prior to administration of any medication.<br><br>e. The medication must be in the original pharmacy-dispensed container with proper label | S 565 | | |

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Adm. — (X6) DATE: 11/05/2025



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| S 565 | Continued From page 1 | S 565 | | |

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.

h. Individual medication records must be

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| S 565 | Continued From page 2<br>retained for each resident to whom medications are being administered and each dose administered to the resident must be properly recorded.<br><br>i. Any medication administered by the residence and refused by a resident shall be documented and reported, as appropriate.<br><br>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.<br><br>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.<br><br>l. All centrally stored medications shall be maintained in accordance with manufacturer's labeling and administered by authorized personnel.<br><br>This Requirement is not met as evidenced by:<br>Based on record review, and resident and staff interviews, it has been determined the residence failed to ensure a resident was identified prior to administration of any medication for the singular resident reviewed for medication errors, Resident ID #1.<br><br>Findings are as follows: | S 565 | | |

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| S 565 | Continued From page 3<br><br>According to Basic Nursing, Mosby, 3rd edition, "The five guidelines to ensure safe drug administration include the right drug, the right dose, the right client, the right route, and the right time."<br><br>Review of the "Medication Aide Job Description" reveals "...2. Pass medications per directive of your Nurse Manager and the resident's physicians..."<br><br>Review of the "Medication Administration Procedure" reveals "...7. All residents are to be identified by using the photograph attached to their respective medication sheet(s)..."<br><br>Review of the "Emergency/General Communications Priority: 1. Urgent-requires immediate response...Call each responder in order, leave voicemail and text if no answer, do not wait to call the next responder... Clinical/Resident Health Issue 1. Nurse Manager...2. Administrator..."<br><br>Review of a facility reported incident submitted to the Rhode Island Department of Health on 10/15/2025 revealed Certified Medication Technician (CMT), Staff A, administered the wrong medication to Resident ID #1 on 10/10/2025 at 7:20 PM. The resident received Gabapentin (a drug used to manage epilepsy and certain types of nerve pain) 100 milligram (mg), in error.<br><br>Record review revealed the resident was admitted to the residence in November of 2024 with a diagnosis including, but not limited to, Alzheimer's disease. | S 565 | | |

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| S 565 | Continued From page 4<br>Review of the comprehensive assessment dated, 11/7/2024, reveals the resident is allergic to Gabapentin.<br><br>Review of the mini-mental state exam, dated 11/7/2024, revealed a score of 22 out of 30, indicating mild dementia.<br><br>Review of a progress note dated 10/11/2025 revealed the next day the resident was more drowsy than normal; the medication error was reported on an internal incident report by Staff A. The family, physician, Nurse Manager, and Administrator were made aware of the error. The family made the decision to send the resident to the Emergency Department for an evaluation.<br><br>During a surveyor interview on 10/21/2025 at 10:00 AM with the Administrator, he revealed he would have expected Staff A to call him if the Nurse Manager was unavailable. He further revealed if the procedure was followed he would have been contacted that night and then the family would have been contacted and the resident would have been sent out the prior day.<br><br>During a surveyor interview on 10/21/2025 at approximately 12:30 PM with the Nurse Manager, he revealed Staff A called Resident ID #2's name and Resident ID #1 answered "yes." He further revealed he would have expected Staff A to ask the resident's name vs. saying the resident's name to prevent giving medication to the wrong resident. If she had a question on which resident was whom, she is to ask a coworker who is familiar with the residents. Furthermore, he could not provide evidence that the medication was administered in a way to prevent administration errors or that Staff A followed protocol following the incident. | S 565 | The submission of this plan of correction is to acknowledge our partnership with the Rhode Island Department of Health in providing residency and services in a safe and secure manner. It is not an admission to the allegation of non-compliance with the Licensing Regulations. | |

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