RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01513	A. BUILDING: _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINGATE RESIDENCES ON THE EAST SIDE	ONE BUTLER AVENUE PROVIDENCE, RI 02906

(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 biennial State Licensure survey was conducted from 10/28/2024 through 10/31/2024 at this residence. Deficiencies were identified relative to the State Licensure survey.	S 003	Neither the preparation nor the execution of this plan consitutes admission or agreement by the provider of truth or the facts alleged of conclusion set forth in the statement of deficiencies. The plan of correction is to comply with provisions of the Rhode Island Licensing statues and regulations.	
S 230	Organization And Management 2.4.13.A Management Of Services 2.4.13 (A/B) Management of Services A. Each residence shall provide services with adequate professional and ancillary employees and in accordance with applicable state law. Further, the residence shall assure that all services are rendered in a safe and effective manner and consistent with the requirements herein. The residence shall provide all care and services to all residents in accordance with the prevailing community standard of care. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined that the residence failed to provide care and services in accordance with the prevailing community standards of care relative to following physician's orders for 1 of 3 sample residents reviewed for self-administration of medication, Resident ID #1. Findings are as follows: According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states in part, "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients."	S 230	S 230 Management of Services Resident #1 orders obtained from PCP for resident to self administer her own medications. A chart audit was completed on all residents and signed physician orders were updated to reflect residents' capacity to self administer their medications. Assessments were updated to reflect the findings. Monthly Audits for 3 months will be reviewed at QA. The Wellness Director will be responsible for completion. Re-education of nurses on physicians clearance form and reconciliation with resident assessment by the Wellness Director. Revised physician Clearance Form (formerly Medication Evaluation Form) will be reviewed as part of the assessment process and will include physicians orders for resident to self administer meds. Physicians orders will be kept updated to reflect changes. Wellness Director and Executive Director will be responsible for compliance.	11/15/24

12/3/24

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — 11/15/24 (X6) DATE

Vincent Messina Executive Director 11/15/24

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S 365	Continued From page 2 been determined that the residence failed to complete and update the comprehensive assessment each time a resident's condition changed significantly for 2 of 2 residents reviewed for outside services, Resident ID #s 4 and 5. Findings are as follows: 1. Record review revealed Resident ID #4 moved into the residence in April of 2024 with a diagnosis including, but not limited to, dementia. Record review of the resident's comprehensive assessment dated 4/3/2024 failed to be updated to accurately document that the resident was no longer receiving occupational therapy services. The assessment further failed to reveal that it was updated to reflect that the resident received speech therapy services due to choking and coughing episodes. Furthermore, the assessment was not updated to include the resident's new diagnosis of dysphagia and the resident's dietary changes on 8/18/2024 to a soft diet, on 8/19/2024 the diet was downgraded to puree, on 8/22/2024 the diet was upgraded to regular consistency solids cut up with gravy, and on 9/4/2024 regular consistency solids, no mixed consistencies. During a surveyor interview on 10/31/2024 at approximately 11:00 AM with the DOW, she could not provide evidence that Resident ID #4's comprehensive assessment was updated to reflect that the resident is no longer receiving occupational therapy services. Additionally, she could not provide evidence that the assessment accurately reflected that the resident was receiving speech therapy, dietary changes, and a new diagnosis of dysphagia (difficulty swallowing).	S 365	All residents residing in licensed apartments will continue to be re-assessed at intervals not to exceed twelve (12) months and each residents condition or a significant change. Monthly audits for 3 months, reviewed at Quality Assurance Meeting, by the Wellness Director Re-education of Nurses on updating assesments for residents receiving outside services. Wellness Director will complete the education. The Wellness Director and or Designee will be responsible for monitoring Compliance. 12/3/24	

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S 370	Continued From page 4 required assessment shall take place within five (5) working days and shall include the following: a. An immediate admission necessitated by natural disaster, crisis, or threat to public safety at another licensed assisted living residence, independent living situation, community residential facility, or private residence; b. An immediate admission necessitated by the unanticipated incapacitation of the primary caregiver of the person to be admitted; c. Conditions or circumstances warranting emergency admission and as approved by Center for Health Facilities Regulation staff within forty- eight (48) hours. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to ensure the resident's comprehensive assessment was updated within five (5) working days of readmission from an admission to a health care facility for a singular resident reviewed for readmission, Resident ID #4. Findings are as follows: Record review revealed the resident was transferred to the hospital after a fall on 9/26/2024 with a subsequent skilled nursing facility admission from 9/29/2024 through 10/7/2024. Record review revealed the last comprehensive assessment was completed on 4/3/2024.	S 370	The Nurse Review process (changes to functional, medical, cognitive status, ancillary therapies,hospice,medication changes, verification of orders, MLOA's) will identify the need for review and update of current assessment and service plan. MLOA tracking of residents out of the building for more than 5 days will result in review and updating current assessment and service plan for any needed changes in condition. Re-education of Nurses of completing the resident assesment with-in 5 working days from readmission to the residency. Completed by the Wellness Director on 11/12/2024. MLOA log will be updated weekly and reviewed during QA meetings with recommendations made to the Executive Director. Wellness Director or Designee will be responsible for monitoring compliance.	

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S 565	Continued From page 6 d. The resident must be identified prior to administration of any medication. 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	S 565	Wellness will report all findings to be reviewed at QA Meetings with recommendations made to the Executive Director. Wellness Director or Designee will be responsible for monitoring compliance.	

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S 565	Continued From page 8 and/or inappropriate access for 2 of 3 medication carts observed, medication carts for the second and third floor. Findings are as follows: 1. During a surveyor observation of the second-floor medication cart on 10/29/2024 at approximately 9:00 AM, in the presence of a Certified Medication Technician (CMT), Staff A, the following medication was filled on 8/16/2024 opened and not dated: - Trelegy Ellipta 100 MCG/62.5 MCG inhaler, manufacturer instructions indicate to discard 6 weeks after opening 2. During a surveyor observation of the third-floor medication cart on 10/29/2024 immediately following the above observation with Staff A, the following medications were opened and expired: - a bottle of polyethylene glycol filled on 7/20/2022 and expired on 7/20/2023 - a tube of muscle rub cream filled on 7/31/2023 and expired on 7/30/2024 - a Ventolin HFA inhaler filled on 4/25/2023 and expired on 4/24/2024 During a surveyor interview with Staff A on 10/29/2024 at approximately 9:00 AM, she could not provide evidence the medications on the cart were stored in a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access. During a surveyor interview with the Director of Wellness on 10/29/2024 at approximately 3:30 PM, she acknowledged the above mentioned medications should be discarded.	S 565		

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S 725	Continued From page 10 reveals the resident was sent to urology due to his/her inability to empty his/her bladder. Further record review of a progress note on 7/10/2024 reveals the resident returned from a skilled nursing facility with an indwelling catheter. An additional review of a progress note on 7/11/2024 states, "SOC (start of care) with Concord skilled nursing on 7/11/2024." The clinical record lacked evidence that a request for a variance was submitted to Rhode Island Department of Health (RIDOH) for catheter care in excess of 45 days. 2. Record review revealed Resident ID #3 moved into the residence in June of 2024 with a diagnosis to include, urinary retention. Review of a progress note dated 7/12/2024 revealed a referral for skilled nursing services for suprapubic catheter care. Record review of the resident's service plan revealed he/she started receiving skilled nursing services on 7/20/2024. The clinical record lacked evidence that a request for a variance was submitted to Rhode Island Department of Health (RIDOH) for catheter care in excess of 45 days. During a surveyor interview on 10/29/2024 at approximately 3:00 PM with the Director of Wellness, she could not provide evidence that variances for catheter care for the above-mentioned residents were sent to RIDOH for approval.	S 725	Resident # 2 and 3's request for Variances were submitted on 11/3/24 with approval on 11/7/24. An audit was completed with all variances being current and up to date. A variance request will be submitted on all established residents for skilled nursing after 45 days. Wellness Director will monitor all requests for variances monthly for 3 months, then review at QA for compliance. Re-education of the Variance Procedure will be completed by the Wellness Director and reviewed by the Vice President of Clinical Services. The Wellness Director and or Designee will be responsible for monitoring compliance .	