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 _____	C 04/10/2026

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 A complaint investigation, ACTS reference numbers 102706, 102551, 101187, 102839, 101135, 101889, 101972, 102024, and 102392, were conducted at this residence on 04/09/2026 through 04/10/2026 to determine compliance with state laws and regulations. Deficiencies were identified.	S 003	Neither the preparation nor the execution of this plan of correction constitutes 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 the provisions of Rhode Island Licensing statutes and regulations.	5/29/26
S 390	Residency Requirements 2.4.17.D Resident Assessment/Service Plans 2.4.17 (D) Resident Assessments and Service Plans D. The assessment shall be reviewed and at intervals not to exceed twelve (12) months and each time a resident's condition changes significantly. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to update the comprehensive assessment each time a resident's condition changed significantly for 3 of 6 residents reviewed; the review included 2 of 4 residents reviewed for outside services, Resident ID #s 1 and 2, and 1 of 2 residents reviewed for behaviors, Resident ID #3. Findings are as follows: Review of a list of residents receiving outside services revealed Resident ID #s 1 and 2. 1) Record review revealed Resident ID #1 moved into the residence in January of 2024 with diagnoses including, but not limited to, dementia and Parkinson's disease.	S 390		

5/4/26

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

EXECUTIVE DIRECTOR 4/27/2026

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S 390	Continued From page 1 Review of the list of residents receiving outside services revealed the resident started receiving physical therapy (PT) services from 9/5/2025 through 10/30/2025 and occupational therapy (OT) services from 10/3/2025 through 11/26/2025. Review of the comprehensive assessment, dated 4/3/2025, failed to be updated to include an end of care date for PT services and a start and end of care date for OT services. During a surveyor interview with the Director of Wellness (DOW) on 4/10/2026 at approximately 2:30 PM, she could not provide evidence that Resident ID #1's comprehensive assessment was updated to include the end of care date for PT services and a start and end date of care for OT services. 2) Record review revealed Resident ID #2 moved into the residence in March of 2025 with a diagnosis including, but not limited to, Alzheimer's disease. Review of the list of residents receiving outside services revealed the resident started receiving palliative care on 4/2/2025 until s/he moved out on 8/24/2025. Review of the comprehensive assessment, dated 3/24/2025, failed to be updated to include a start of care for palliative services beginning 4/2/2025. During a subsequent interview with the DOW at approximately 2:30 PM, she could not provide evidence that Resident ID #2's comprehensive assessment was updated to include the start of palliative care.	S 390	**S 390- Resident Assessments/ Service Plans** Failure to provide proper documentation for Residents #1, 2 & 3 related to failure to update the comprehensive service plan for the following change of condition with outside services with start and end of care dates and / or evidence of updated plan of care notes. A chart audit was conducted on all residents to ensure all residents receiving outside services their charts reflect the COC and the chart was updated to reflect start and end date. Assessments were updated to reflect the same findings. Wellness Director to create a Manual Tickler / Tracking tool to monitor Outside Services and track dates to cross reference with our YARDI (EMR) to ensure residents receiving outside services with dates of start and stop of services are better tracked to meet the regulation.	5/29/26

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S 390	Continued From page 2 3) Record review revealed Resident ID #3 moved into the residence in January of 2025 with a diagnosis including, but not limited to, Alzheimer's disease. During this survey two resident to resident incidents were investigated, including one with Resident ID #3, as the alleged perpetrator. Review of the progress notes revealed the following entries: -1/31/2025, "...Resident unable to be redirected, going in and out of other residents room. Throwing objects at staff..." -2/2/2025, "...declined to take [his/her] medications several times this morning...Since lunch [he/she] has been difficult to redirect, wandering into rooms, taking objects..." -2/3/2025, "...resident walking around unit with no pants on, unable to redirect, trying to hit staff, spit out some of [his/her] meds, refuse care..." -2/11/2025, "...Resident with intermittent periods of increased agitation, and restlessness throughout the shift. Difficult to redirect at times with resident becoming short and...aggressive toward staff..." -2/26/2025, "...Per 11-7 staff. Resident was wandering, trying to enter other resident's rooms, urinated on the floor, was unable to be redirected and was combative with staff..." -2/27/2025, Spoke with psychiatric provider, "...discussed [resident] behaviors and general times that [he/she] becomes agitated..." Review of the comprehensive assessment, dated 1/28/2025, revealed the resident does not have any current or history of disruptive, aggressive, verbally, or socially inappropriate behaviors.	S 390	Audit findings will be reviewed during QA meetings with any recommendations to the ED, along with Nursing Re-education. Wellness Director or Designee will be be responsible for monitoring compliance.	

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S 390	Continued From page 3 During a subsequent interview with the DOW at approximately 2:35 PM, she was unable to provide evidence that the resident's comprehensive assessment was updated to include behaviors.	S 390		
S 400	Residency Requirements 2.4.17.F Resident Assessments/Service Plans 2.4.17 (F) Nurse Review 1. Nurse review is necessary for all levels of licensure. a. A registered nurse shall visit the residence at least once every thirty (30) days except as provided in § 2.4.16(F)(1)(b) of this Part and shall complete a review to include the following: (1) Monitor the medication regimen for all residents; (2) Review any new physician orders and evaluate the health status of all residents by identifying symptoms of illness and/or changes in mental/physical health status; (3) Evaluate the appropriateness of placement for each resident; (4) Make any necessary recommendations to the administrator; (5) Follow up on previous recommendations; (6) Provide a signed, written report in the residence documenting:	S 400	**S 400- Nurse Review** Resident #1,4,5,6 & 7- based on survey findings were non-compliant with 90-day nurse reviews. A complete audit of all residents was completed to ensure 90-day nurse reviews are completed timely. A Manual audit tool will be created along with our YARDI (EMR) system and will be used to track all 90-day Nurse Reviews for ensured compliance and accuracy. Audit findings will be reviewed during QA meetings with any recommendations made to the ED, along with Nursing Re-education. Wellness Director or Designee will be responsible for monitoring compliance.	5/29/26

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S 400	Continued From page 4 (AA) Date and time of assessment; (BB) Recommendations for follow-up; (CC) Progress on previous recommendations; (DD) Verification that the medication listed by the pharmacist on the mediset, blister pack or medication container is current with physician orders (M-1 level only); (EE) Physical assessment identifying symptoms of illness and/or changes in mental or physical health status and appropriateness of placement; (FF) Such reports shall be on file at the residence. (7) Complete the quarterly evaluation of the residence ' s registered medication aide(s) administration of medication. (Approved Department form is available for downloading online). b. In those residences that have one (1) or more licensed registered nurses (i.e., at least one (1) full-time equivalent equal to thirty-five (35) hours) on-site, the nurse review shall be completed at least once every ninety (90) days. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to complete nurse reviews every 90 days, as required, for 5 of 11 sample residents reviewed, Resident ID #s 1,	S 400		

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S 400	Continued From page 5 4, 5, 6, and 7. Findings are as follows: Record review revealed Resident ID #s 1, 4, 5, 6, and 7 had missing nurse reviews, as follows: 1) Record review revealed Resident ID #1 moved into the residence in January of 2024 with diagnoses including, but not limited to, dementia and Parkinson's disease. Record review failed to reveal evidence of nurse reviews completed every ninety days after the last one dated 4/23/2025. The resident was discharged from the facility in January of 2026. 2) Record review revealed Resident ID #4 moved into the residence in May of 2025 with a diagnosis including, but not limited to, Alzheimer's disease. Record review failed to reveal evidence of nurse reviews completed every ninety days after the last one dated 7/24/2025. 3) Record review revealed Resident ID #5 moved into the residence in July of 2023 with a diagnosis including, but not limited to, dementia. Record review failed to reveal evidence of nurse reviews completed every ninety days after the last one dated 8/19/2025. 4) Record review revealed Resident ID #6 moved into the residence in February 2024 with a diagnosis including, but not limited to, dementia. Record review failed to reveal evidence of nurse reviews completed every ninety days after the last comprehensive assessment dated 2/14/2025.	S 400		

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S 400	Continued From page 6 5) Record review revealed Resident ID #7 moved into the residence in June of 2024 with a diagnosis including, but not limited to, asthma. Record review failed to reveal evidence of nurse reviews completed every ninety days after the last comprehensive assessment dated 9/29/2025. During a surveyor interview with the Director of Wellness on 4/10/2026 at approximately 2:30 PM, she acknowledged the above-mentioned nurse reviews were not completed for the above-mentioned residents.	S 400		
S 415	Residency Requirements 2.4.17.G.3 Resident Assessment/Service Plan 2.4.17 (G)(3) Service Plans 3. The service plan shall be reviewed by both parties at intervals not to exceed twelve (12) months and each time a resident's condition changes significantly and all changes shall be acknowledged in writing by both parties. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to update the service plan each time a resident's condition changed significantly for 3 of 6 residents reviewed; the review included 2 of 4 residents reviewed for outside services, Resident ID #s 1 and 2, and 1 of 2 residents reviewed for behaviors, Resident ID #3. Findings are as follows:	S 415	**S 415- Residency Requirements - Resident Assessments and Service Plans** Residents #1,2 & 3 failed to provide proper documentation that residents receiving outside services were listed with SOC/EOC along with significant changes documented and updated. Residents' assessments to be updated with all SOC/EOC and significant changes updated to reflect care and behavior changes referenced in Resident 3#.	5/29/26

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S 415	Continued From page 7 Review of a list of residents receiving outside services revealed Resident ID #s 1 and 2. 1) Record review revealed Resident ID #1 moved into the residence in January of 2024 with diagnoses including, but not limited to, dementia and Parkinson's disease. Review of the list of residents receiving outside services revealed the resident started receiving physical therapy (PT) services from 9/5/2025 through 10/30/2025 and occupational therapy (OT) services from 10/3/2025 through 11/26/2025. Review of the service plan, dated 4/3/2025, failed to be updated to include an end of care date for PT services and a start and end of care date for OT services. During a surveyor interview with the Director of Wellness (DOW) on 4/10/2026 at approximately 2:30 PM, she could not provide evidence that Resident ID #1's service plan was updated to include the end of care date for PT services and a start and end date for OT services. 2) Record review revealed Resident ID #2 moved into the residence in March of 2025 with a diagnosis including, but not limited to, Alzheimer's disease. Review of the list of residents receiving outside services revealed the resident started receiving palliative care on 4/2/2025 until s/he moved out on 8/24/2025. Review of the service plan, dated 3/24/2025, failed to be updated to include a start of palliative care on 4/2/2025.	S 415	A chart audit was conducted on all residents for compliance to ensure all residents receiving outside services their charts reflect the COC and the chart was updated to reflect start and end date. Assessments were updated to reflect the same findings. The Audit will be reviewed during QA meetings with any recommendations made to the ED, along with Nursing Re-education. Wellness Director or Designee will be responsible for monitoring compliance.	

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S 415	Continued From page 8 During a subsequent interview with the DOW at approximately 2:30 PM, she could not provide evidence that Resident ID #2's service plan was updated to include the start of palliative care. 3) Record review revealed Resident ID #3 moved into the residence in January of 2025 with a diagnosis including, but not limited to, Alzheimer's disease. During this survey two resident to resident incidents were investigated, including one with Resident ID #3, as the alleged perpetrator. Review of the progress notes revealed the following entries: -1/31/2025, "...Resident unable to be redirected, going in and out of other residents room. Throwing objects at staff..." -2/2/2025, "...declined to take [his/her] medications several times this morning...Since lunch [he/she] has been difficult to redirect, wandering into rooms, taking objects..." -2/3/2025, "...resident walking around unit with no pants on, unable to redirect, trying to hit staff, spit out some of [his/her] meds, refuse care..." -2/11/2025, "...Resident with intermittent periods of increased agitation, and restlessness throughout the shift. Difficult to redirect at times with resident becoming short and...aggressive toward staff..." -2/26/2025, "...Per 11-7 staff. Resident was wandering, trying to enter other resident's rooms, urinated on the floor, was unable to be redirected and was combative with staff..." -2/27/2025, Spoke to psychiatric provider, "...discussed [resident] behaviors and general times that [he/she] becomes agitated..."	S 415		

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S 415	Continued From page 9 Review of the service plan, dated 3/24/2025, revealed the resident has no behavior issues. "...Resident does not have current or history of disruptive, aggressive, verbal or socially inappropriate behavior..." During a subsequent interview with the DOW at approximately 2:35 PM, she was unable to provide evidence that the resident's service plan was updated to include behaviors.	S 415		