RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01499	A. BUILDING: _____ B. WING _____	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLESGATE SENIOR LIVING CENTER	670 NORTH MAIN STREET PROVIDENCE, RI 02904

(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 and a complaint/incident investigation survey (D9XG11, 10/24/2025) were conducted at this residence. Deficiencies were identified relative to the State Licensure survey.	S 003		
S 055	Licensure Requirements 2.4.3 Quality Assurance 2.4.3 Quality Assurance A. In accordance with R.I. Gen. Laws § 23-17.4-10.1, each assisted living residence shall develop, implement and maintain a documented, ongoing quality assurance program. 1. The purpose of this program shall be to attain and maintain a high quality assisted living residence through an on-going process of quality improvement that monitors quality, identifies areas to improve, methods to improve them, and evaluates the progress achieved. 2. Each licensed residence shall establish a quality improvement committee which shall include at least the following: assisted living administrator, registered nurse and a representative of dietary services. 3. The quality improvement committee shall meet at least quarterly; shall maintain records of all quality improvement activities; and shall keep records of committee meetings that shall be available to the Department during any onsite visit. 4. The quality improvement committee shall review and approve the quality improvement plan for the residence at intervals not to exceed twelve (12) months. Said plan shall be available to the	S 055	Received NOV 10 2025 Facilities Regulation 11/28/25	

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE Executive Director — (X6) DATE 11/10/2025

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S 055	Continued From page 1 public upon request. 5. Each assisted living residence shall establish a written quality improvement plan that includes: a. Program objectives; b. Oversight responsibility (e.g., reports to the governing body, QI records); c. Includes methods to identify, evaluate, and correct identified problems; d. Provides criteria to monitor personal assistance and resident services, including, but not limited to: (1) Resident/family satisfaction; (2) Medication administration/errors; (3) Reportable incidents as specified in § 2.4.17 of this Part; (4) Resident falls; (5) Plans of correction developed in response to the Department ' s inspection reports. B. In addition to the requirements of §§ 2.4.3(A) (1) through (5) of this Part, all assisted living residences with a "dementia care" license and/or a "limited health services license" shall also address the following areas in their quality improvement plan: a. Prevention and treatment of decubitus	S 055		

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S 055	Continued From page 2 ulcers; b. Dehydration, and nutritional status and weight loss or gain; and c. Changes in mental or psychological status. 1. Quality improvement documentation shall be kept on file for a minimum of five (5) years. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to review and approve the quality assurance (QA) plan at intervals not to exceed twelve months, as required. Findings are as follows: Record review of the residence's QA plan revealed the plan was last reviewed and approved in January of 2022. Addition record review failed to reveal evidence the QA plan had been reviewed at intervals not to exceed twelve months, as required. During a surveyor interview on 10/24/2025 at 10:25 AM with the Administrator, she was unable to provide evidence the QA plan had been reviewed and approved at intervals not to exceed twelve months, as required, since January 2022.	S 055	The citation ***S055 Licensure Requirements 2.4.3 Quality Assurance*** *contends that the* residence failed to "review and approve the QA Plan at intervals not to exceed twelve months." All community policies are reviewed annually according to regulatory requirements and confirmed by administrator's signature. The Quality Assurance Plan is also reviewed annually. The annual Policy and Procedure review was completed and signed in January 2025 (Exhibit A). The Quality Assurance Plan was re-dated and signed by all required present administrative staff in August of 2024, additionally the Quality Assurance Plan and Policy were reviewed, signed and updated in the policy book (Exhibit B) on 10/24/2025.	
S 565	Residential Care Services 2.4.24.B.1 Medication Services 2.4.24 (B) (1) Administration of Medications	S 565	No residents have been harmed related to this citation and compliance was established on 10/24/2025.	

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S 565	Continued From page 3 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. 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	S 565		

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S 565	Continued From page 4 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 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	S 565		

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S 565	Continued From page 5 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 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 practice and in accordance with a written physician's order for one of three residents reviewed, 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 that the orders are in error or would harm the clients." Record review revealed Resident ID #1 moved into the residence in October of 2014 with a	S 565	Citation **S 565 Residential Care Services 2.4.24.B.1 Medication Services** indicates that the Community's electronic MAR was not updated timely, and that Resident ID#1 was not administered monthly Vitamin D2 prescribed by his physician on 6/23/2024. Firstly, documentation was presented at the time of Survey, that the medication in question was discharged by the original prescribing Physician on 7/18/2024. See Exhibit C. This explains why the medication was not documented as given on 7/20, 8/17, 9/14, and 10/12/2024. It was not administered because it had been discharged. The community acknowledges that the order should not have been left active in the MAR after it had been discharged, as pharmacy failed to discontinue it, and posted the medication for a 4 AM administration time. The monitoring mechanism we had in place to address issues like this one, did not catch this issue, and since there is no medication pass at 4AM at Charlesgate, it was not easily recognized by our staff.	

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S 565	Continued From page 6 diagnosis including, but not limited to, a traumatic brain injury. Record review of a physician's order dated June 23, 2024, revealed an order for Vitamin D2 1.25 milligram (mg) 50,000 units to be administered monthly. Record review of the Medication Administration Record (MAR) for 2025 revealed the above-mentioned medication was not signed off on the MAR as being administered monthly, as ordered on the following dates: - July 20 - August 17 - September 14 - October 12 During a surveyor interview on 10/23/2025 at 2:19 PM with the Wellness Director, she was unable to provide evidence the above-mentioned medication was administered to the resident, as ordered. Additionally, she indicated that if a medication was discontinued, it should not be reflecting on the MAR to be administered.	S 565	To ensure that Resident ID#1, is being provided appropriate medications and that he was not negatively impacted by this issue, Charlesgate Nursing referred the situation to his current medical provider, since the original provider no longer serves him. The current provider did lab work and determined Resident ID#1's vitamin D levels were within normal limits, and his current order of Vitamin D was reduced from 2 tabs to 1 tab daily (See updated med list as Exhibit D). All corrections were made in the MAR on 10/28. Resident ID #1 was not harmed by this discharge notation oversight, since the medication was discharged in July of 2024, and he was regularly getting the prescribed dose daily. To complete this plan of correction, our Monitoring Mechanism has been updated. Nurse Supervisors will complete a monthly audit of the MAR, ensuring all discharged medications are documented properly, and will be tracked in our quarterly QA meeting. Please see Exhibit E "Medication Reconciliation" quality indicator and Monthly Medication Reconciliation Sheet. Compliance was achieved On 10/28/2025.	