STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPUER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01510	A. BUILDING: _____ B. WING _____	C 12/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINGATE RESIDENCES ON BLACKSTONE BO	353 BLACKSTONE BOULEVARD 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)	(XS) COMPLETE DATE
S 003	Initial Comments An unannounced complaint/incident investigation survey, ACTS reference number 93312, 93244, 93533 was conducted at this residence on 12/29/2023. Deficiencies were identified.	S003	RECEIVED JAN 26 2024 FACILITIES REGULATION	
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 prevailing community standards of care relative to a physician order for one of two sample residents, 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 physicians' orders unless they believe the orders are in error or would harm the clients..."	S230	All controlled medication boxes will be checked for discontinued narcotics. Education will be provided to the licensed nurses and CMT's regarding immediate destruction of discontinued narcotics including a review of the community Medication Destruction Policy. The controlled medication boxes will be audited weekly by the Wellness Director or designee for 90 days to ensure all discontinued narcotics are destroyed. Education was provided to the licensed staff regarding procedure for discontinuing medications. The controlled medication boxes will be audited weekly by the Wellness Director or designee for 90 days against EMAR and Narcotic Book to ensure all discontinued controlled medications have been removed from the controlled medication box.	2/9/2024 2/9/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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5 230	Continued From page 1 According to the facility medication error policy, a medication error occurs if a medication is "...given after the [discontinued] date, any medication given after it has been discontinued by the physician..." Record review revealed ID #1 was admitted to the residence in July of 2022 with diagnoses including, but not limited to: type II diabetes, dementia, and cognitive communication deficit. Record review revealed a hospice care coordination note which indicates the resident was admitted to hospice on 11/20/2023 for complications due to Alzheimer's disease. Record review of a hospice care coordination note dated 12/18/2023 reveals, "...Upon arrival spoke with [Staff A] who reports patient was given [as needed) Oxycodone this weekend. Medication is not listed in patient med profile as it was [discontinued]..." Record review of ID #1's medication list reveals Oxycodone was discontinued on 11/21/2023, a month prior to this incident. During an interview on 12/29/2023 at approximately 5:30 PM, the Resident Services Director and Administrator acknowledged the medication was given without a physician's order, resulting in a medication error.	5230		
S 365	Residency Requirements 2.4.16.D Resident Assessment/Service Plans 2.4.16 (d) Resident Assessments and Service Plans	5365		

DM EO 1/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 365	I Continued From page 2 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 review the resident's comprehensive assessment at intervals not to exceed (12) months and each time a resident's condition changes significantly for two of two sample residents reviewed, Resident ID #s 1 and 2. Findings are as follows: 1) Record review revealed ID #1 was admitted to the residence in July of 2022 with diagnoses including, but not limited to: type II diabetes, dementia, and cognitive communication deficit. Record review revealed a hospice care coordination note indicating Resident ID #1 was admitted to hospice on 11/20/2023 for complications from Alzheimer's disease. The record revealed ID #1's last comprehensive assessment to be dated 8/16/2023, which failed to reveal an update to reflect the admission to hospice care. 2) Record review revealed ID #2 was admitted to the residence in June of 2023 with diagnoses including, but not limited to: Parkinson's disease and glaucoma. Record review of facility 5-day investigation reports revealed that ID #2 had a fall on 11/25/2023 and 12/2/2023, both resulting in	S 365	All resident records will be reviewed to ensure 90-Day Nurse reviews were completed since 11/1/2023. The Appendix C assessments will be audited to ensure any significant change in condition, admission to outside services (including Hospice), and all care items are accurate. All resident records will be audited by the Wellness Director or designee to ensure comprehensive assessment intervals have not exceeded 12 months and that 90-day Nurse review assessments are scheduled appropriately for 90 days. Executive Director and Wellness Director will sign off monthly on the assessment schedule. All licensed nursing staff will be educated on the assessment process, including change in condition, inclusion of outside services (Hospice, VNA, PT/OT, Private Duty), accuracy of care needs, and timely completion of all assessments.	2/9/2024

1/29/24

DLN EO 1/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTJPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINGATE RESIDENCES ON BLACKSTONE BO	353 BLACKSTONE BOULEVARD PROVIDENCE, RI 02906

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s 365	Continued From page 3 hospitalization. During an interview on 12/29/2023 at approximately 4:30 PM the Administrator revealed that these falls were attributed to ID #2's Parkinson's diagnosis and that the facility has put in place staff escorts to and from meals as a safety precaution. Resident ID #2's last comprehensive assessment dated 7/31/2023, failed to reflect the addition of staff escorts to and from meals related to fall risk. During an interview on 12/29/2023 at approximately 5:30 PM, the Resident Services Director was unable to provide evidence the assessments for Resident ID #s 1 and 2 had been updated as required.	S365		
s 375	Residency Requirements 2.4.16.F Resident Assessment/Service Plans 2.4.16 (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;	S375		

DCN EO 1/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 375	Continued From page 4 (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: (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	S 375		

EO 1/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 375	Continued From page 5 online). b. In those residences that have one or more licensed registered nurses (i.e., at least one 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 ensure nurse reviews were completed at least once every ninety (90) days and reflected changes of condition for one of two sample residents, Resident ID #1. Findings are as follows: Record review revealed ID #1 was admitted to the residence in July of 2022 with diagnoses including, but not limited to type II diabetes, dementia, and cognitive communication deficit. Record review revealed the resident's last nurse review to be dated 2/5/2023. There was no evidence of a nurse review completed every ninety days before or after the comprehensive assessment on 08/16/2023. During an interview on 12/29/2023 at approximately 5:30 PM, the Resident Services Director was unable to provide evidence Resident ID #s 1 nurse review was completed at least once every ninety days, as required.	S375		
S 565	Residential Care Services 2.4.24.B.1 Medication Services	S565		

DM 1/26/24

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S 565	Continued From page 6 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. 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	S 565		

DCM 1/24/24

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S 565	Continued From page 7	S 565		

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 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.

Del to 1/26/24

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S 565	Continued From page 8 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 record review and staff interview, it has been determined the residence failed to ensure that medications shall be administered in accordance with written orders of a physician, stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access for one of two residents reviewed, Resident ID #1. .Findings are as follows: According to the facility medication error policy, a medication error occurs if a medication is "...given after the [discontinued] date, any medication given after it has been discontinued by the physician..." Record review revealed ID #1 was admitted to the residence in July of 2022 with diagnoses including, but not limited to: type II diabetes,	S 565		

1/26/24

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S 565	Continued From page 9 dementia, and cognitive communication deficit. Record review revealed a hospice care coordination note which indicates the resident was admitted to hospice on 11/20/2023 for complications due to Alzheimer's disease. Record review of a hospice care coordination note dated 12/18/2023 reveals, "...Upon arrival spoke with [Staff A] who reports patient was given [as needed] Oxycodone this weekend. Medication is not listed in patient med profile as it was [discontinued]..." Record review of ID #1's medication list reveals Oxycodone was discontinued on 11/21/2023, a month prior to this incident. Surveyor interview on 12/29/2023 at approximately 4:00 PM with Staff B, Licensed Practical Nurse, revealed that the facility policy is to dispose of discontinued medication immediately. She further revealed that narcotics are to be disposed of by two staff. During an interview on 12/29/2023 at approximately 5:30 PM, the Resident Services Director acknowledged the facility did not discard this discontinued medication in a timely manner to prevent medication errors.	S 565		

1/26/24