RI Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALR01494 | A. BUILDING: _____ B. WING _____ | 01/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ST CLARE - NEWPORT | 309 SPRING STREET NEWPORT, RI 02840 |

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| S 003 | Initial Comments<br><br>An unannounced biennial State Licensure survey and a complaint/incident investigation survey (AYEH11, 01/26/2024) were conducted at this residence. Deficiencies were identified relative to the State Licensure survey. | S 003 | | |
| S 375 | Residency Requirements 2.4.16.F Resident Assessment/Service Plans<br><br>2.4.16 (F) Nurse Review<br><br>1. Nurse review is necessary for all levels of licensure.<br><br>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:<br><br>(1) Monitor the medication regimen for all residents;<br><br>(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;<br><br>(3) Evaluate the appropriateness of placement for each resident;<br><br>(4) Make any necessary recommendations to the administrator;<br><br>(5) Follow up on previous recommendations;<br><br>(6) Provide a signed, written report in the residence documenting: | S 375 | Resident #1, is current with 90 day nurse review.<br><br>Resident #3, is current with 90 day nurse review.<br><br>Reisdent #4, is current with 90 day nurse review.<br><br>An audit was conducted of all residents to ensure compliance with required 90 day nurse reviews. All required nurse reviews are current and up to date.<br><br>Education was provided to the Program Director and Wellness Nurse.<br><br>Audits will be conducted monthly by the Executive Director/designee and findings will be presented to the QAPI committee until the committee determines compliance has been achieved.<br><br>The Executive Director is responsible to ensure compliance.<br><br>RECEIVED<br>FEB 5 2024<br>FACILITIES REGULATION | 2/7/2024 |

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director | 2/5/2024

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| S 375 | Continued From page 1<br>(AA) Date and time of assessment;<br>(BB) Recommendations for follow-up;<br>(CC) Progress on previous recommendations;<br>(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);<br>(EE) Physical assessment identifying symptoms of illness and/or changes in mental or physical health status and appropriateness of placement;<br>(FF) Such reports shall be on file at the residence.<br>(7) Complete the quarterly evaluation of the residence's registered medication aide(s) administration of medication. (Approved Department form is available for downloading online).<br>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.<br>This Requirement is not met as evidenced by:<br>Based on record review and staff interview, it has been determined the residence failed to complete nurse reviews every 90 days as required for 3 of 4 sample residents reviewed, ID #s 1, 3, and 4. | S 375 | | |

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| S 375 | Continued From page 2<br><br>Findings are as follows:<br><br>1. Record review revealed Resident ID #1 moved into the residence in April of 2019 with a diagnosis of dementia.<br><br>Record review revealed the resident had nurse a review completed on 7/17/2022 and did not have another nurse review until 11/22/2023. The record failed to reveal evidence that a 90-day nurse review was completed every 90 days, as required.<br><br>2. Record review revealed Resident ID #3 moved into the residence in November of 2008 with a diagnosis of Alzheimer's disease.<br><br>Record review revealed the resident had a nurse review completed on 7/25/2022 and did not have another nurse review completed until 7/25/2023. The record failed to reveal evidence that a 90-day nurse review was completed every 90 days, as required.<br><br>3. Record review revealed Resident ID #4 moved into the residence in October of 2021 with a diagnosis of dementia.<br><br>Record review revealed the resident had his/her first nurse review completed on 7/25/2023. Record review failed to reveal evidence that a 90-day nurse review was completed prior to that date and every 90 days, as required.<br><br>During a surveyor interview on 1/26/2024 at approximately 11:22 AM with the Executive Director, she was unable to provide evidence that the nurse reviews were completed every 90 days, as required, for Resident ID #s 1, 3, and 4. | S 375 | | |

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| S 390 | Residency Requirements 2.4.16.G.3 Resident Assessment/Service Plan<br><br>2.4.16 (G)(3) Service Plans<br><br>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.<br><br>This Requirement is not met as evidenced by:<br>Based on record review and staff interview, it has been determined the residence failed to review the service plan at intervals not to exceed twelve (12) months, and update the service plan each time a resident's condition changes significantly. Additionally, the residence failed to accurately reflect that the resident is receiving outside services for 2 of 4 sample residents reviewed, ID #s 1 and 3.<br><br>Findings are as follows:<br><br>1. Record review revealed Resident ID #1 moved into the residence in April of 2019 with a diagnosis of dementia.<br><br>Record review of a list of residents receiving outside services provided by the Registered Nurse Program Director, revealed evidence the resident is receiving hospice services with a start of care date of 6/3/2023.<br><br>Record review of a service plan dated 10/27/2023 failed to reveal evidence the service plan was updated to reflect the resident is receiving the above-mentioned outside services. | S 390<br><br>2/6/24 | Resident #1, service plan is updated to reflect current outside services being provided.<br><br>Resident #3, service plan is current and up to date.<br><br>An audit was conducted of all resident's service plans to ensure compliance. Service plan form was reviewed and updated.<br><br>Education was provided to the Program Director and Wellness Nurse.<br><br>Audits will be conducted monthly by the Executive Director/designee and findings will be presented to the QAPI committee until the committee determines compliance has been achieved.<br><br>The Executive Director is responsible to ensure compliance. | 2/7/2024 |

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| S 390 | Continued From page 4<br><br>2. Record review revealed Resident ID #3 moved into the residence in November of 2008 with a diagnosis of Alzheimer's disease.<br><br>Record review revealed the resident's service plan was reviewed on 2/3/2021 and on 11/3/2023. Record review failed to reveal evidence the service plan was reviewed in 2022.<br><br>During an interview on 1/26/2024 at approximately 11:22 AM with the Executive Director, she could not provide evidence the service plan for Resident ID #1 was updated to reflect the outside services the resident is receiving. Additionally, she could not provide evidence Resident ID #3 service plan was reviewed at an interval not to exceed twelve months, as required. | S 390 | | |
| 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. | S 565 | Second floor - all expired or not labeled medications were immediately disposed of.<br><br>Third floor - all medications were immediately labeled with resident identifier and directions for use.<br><br>An audit was conducted of all medication carts to ensure compliance with requirement.<br><br>Education was provided to the Certified Medication Technicians.<br><br>Audits will be conducted weekly by the Program Director/designee and findings will be presented to the QAPI committee until the committee determines compliance has been achieved.<br><br>The Executive Director is responsible to ensure compliance | 2/7/2024 |

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| S 565 | Continued From page 5<br>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 and directions attached and be administered in accordance with such label.<br><br>f. Injectable medications, including but not limited to insulin, which cannot be self-administered by the resident, must be administered by a licensed nurse.<br><br>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).<br><br>(1) The legal destruction of hypodermic needles, syringes or other such instruments is the responsibility of the last entitled or authorized possessor.<br><br>(AA) All personnel or residents legally authorized to use disposal syringes and needles, shall destroy them after one (1) use.<br><br>(BB) Excess and undesired needles, syringes and other such instruments shall be | S 565 | | |

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| S 565 | Continued From page 6<br>stored in impervious, rigid, puncture- resistant container for disposal. Intact needles shall be placed directly into the collection containers.<br><br>(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.<br><br>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.<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. | S 565 | | |

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| S 565 | Continued From page 7<br><br>This Requirement is not met as evidenced by:<br>Based on surveyor observation and staff interview, it has been determined the residence failed to ensure that medications shall be stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access for the 2 of 3 medication carts observed.<br><br>Findings are as follows:<br><br>1. During a surveyor observation of the second-floor medication cart on 1/25/2024 at approximately 10:42 AM in the presence of the Registered Nurse Program Director, the following was revealed:<br><br>- Methotrexate Sodium (a medication used to treat eye inflammation) 25 MG (milligram) with an expiration date of "January 2023."<br><br>- Wixela 100/50 (a medication used to treat lung disease) MCG (microgram) inhaler, opened and not dated. Manufacturer instructions indicate to discard inhaler one month after opening.<br><br>- Brimonidine Tartrate 0.2% eye drop (a medication used to treat high pressure in the eyes), opened and not dated. Manufacturer instructions indicate to discard 4 weeks after opening.<br><br>2. During a surveyor observation of the third-floor medication cart on 1/25/2024 at approximately 10:45 AM in the presence of a Certified Medication Technician (CMT), Staff A revealed the following medications without directions for use and a resident identifier: | S 565 | | |

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| S 565 | Continued From page 8<br><br>- Melatonin 3 MG<br>- Vitamin C 250 MG<br>- Two bottles of Aspirin 325 MG<br>- Three bottles of Acetaminophen 500 MG<br>- Three bottles of Aspirin 81 MG<br>- Acetaminophen 325 MG<br><br>During an interview immediately following this observation with Staff A, she acknowledged the above-mentioned medications did not have directions for use and a resident identifier.<br><br>During an interview on 1/25/2024 at approximately 10:50 AM with the Registered Nurse Program Director, she acknowledged the above-mentioned medications were not stored appropriately, as required. | S 565 | | |