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 _____	C 06/24/2025

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 complaint/incident investigation survey, ACTS reference numbers 101265, 101282, 101247, 100800, 100758, 100721, and 100321, was conducted at this residence on 06/23/2025 through 06/24/2025 to determine compliance with state regulations. A deficiency was identified.	S 003		
S 565	Residential Care Services 2.4.24.B.1 Medication Services 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.	S 565	Received JUL 16 2025 Facilities Regulation AM 7/17/25	

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lauren J. Yolen — TITLE: Executive Director — (X6) DATE: 7/14/2025

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S 565	Continued From page 1 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 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.	S 565		

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S 565	Continued From page 2 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 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 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 single resident reviewed for a medication administration error, Resident ID #1.	S 565	**Plan of Correction for the State Complaint Investigation conducted at Charlesgate Senior Living Center on 06/24/2025.** The non-compliance citation of *S565 Residential Care Services Requirements 2.4.24.B.1* determined that the residence failed to ensure that medications are stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access for resident ID#1. As a plan of correction, Charlesgate Senior Living Center has implemented the following:	

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S 565	Continued From page 3 Findings are as follows: Review of a facility reported incident sent to the Rhode Island Department of Health on 6/17/2025 revealed Resident ID #1 injected himself/herself with 60 units of insulin that belonged to Resident ID #2. During a surveyor interview with the Certified Medication Technician (CMT), Staff A, on 6/23/2025 at 11:10 AM, she revealed Resident ID #1 has diabetes and is prescribed Ozempic (a prescription medication used to manage type 2 diabetes in adults; it is administered as a once-weekly injection). She further revealed the resident came into the medication room, went to the drawer to get his/her glucometer (used to test blood sugar levels), and tested his/her blood sugar. The resident then proceeded to an unlocked cabinet where other residents' medication boxes containing insulin were stored. Staff A revealed she went over to Resident ID #1 to check the insulin and then went back to the medication cart. She indicated she then realized the resident injected himself/herself with Resident ID #2's insulin. Record review of the physician's order for Resident ID #1's insulin revealed the following order: -Ozempic 1 mg (milligram)/dose (4 MG/3 M (Semaglutide). Inject 1 MG subcutaneously (SQ) every 7 days. Record review of the physician's order for Resident ID #2's insulin revealed the following order:	S 565	Storage of all insulin and injectable medications has been moved to locked areas. All locks on medication cabinets and drawers have been inspected and determined to be in working order. Residents have no access to locked medication Locations. Licensed and appropriate staff must remove all medications from locked storage, ensure the correct resident is getting the correct physician prescribed medication, and administer the medication to the resident. In cases where the resident will self-administer medication, the licensed personnel will hand the medication to the resident, observe self-administration, and properly document. Enhancements have been made in the residence's Medication Administration Policy to ensure that this procedure is clear and enforced. Please see Exhibit A. Active certified medication staff have been educated and signed off on the clarified med tech procedure. See Exhibits B and C. Continued education for med techs on state regulation Residential Care Services Requirements 2.4.24.B.1 Medication Services will be on-going. Resident ID#1: returned to the community on 6/23/2025, is doing well and no further negative effect has occurred. Resident ID#1 has also been educated on medication procedures. The Director of Resident Care has re-assessed ID#1 and ensured that she	

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S 565	Continued From page 4 -Insulin aspart (a rapid acting insulin used to treat diabetes) 100 units/ml. Inject 20 units SQ with breakfast, 25 units before lunch and supper. During a surveyor observation of the medication room on 6/23/2025 at approximately 11:20 AM in the presence of Staff A, she showed this surveyor the unlocked cabinet where the insulin for Resident ID #s 1 and 2 were stored. During a surveyor interview with the Director of Wellness on 6/24/2025 at 8:17 AM, she could not provide evidence the residents' above-mentioned insulins were stored appropriately to prevent administration errors.	S 565	remains eligible for residency. Nurse monitoring of her Ozempic administration continues. Furthermore, we have put measures in place to our Quality Assurance Program, beginning July 2025 to monitor our strict compliance to Residential Care Services Requirements 2.4.24.B.1 Medication Services. Auditing of injectable medication documentation by a nurse will continue weekly. Unannounced audits will be carried out to ensure that all medication storage spaces remain inaccessible to residents. We will continue to include the monitoring of the Injectable Medication Administration Quality Indicator in our Quality Assurance Program for at least one year. Please see examples of the quality indicator audit sheets attached as Exhibit D. Compliance date was established on 7/14/2025.	7/14/2025