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 _____	01/12/2023

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 An unannounced biennial State Licensure survey was conducted at this residence. Deficiencies were identified.	S 003	*Neither the preparation nor the execution of this plan 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 statues and regulations.*	**2/21/2023**
S 230	Organization And Management 2.4.13(A/B) Management Of Services DTP 3/3/23 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. B. The residence shall have a policy and procedure manual that is reviewed and updated by the administrator at intervals not to exceed twelve (12) months, and shall include, but not be limited to, the following items: 1. A written description of all services available to residents that shall be designed to promote the resident's efforts to maintain independence; 2. A written statement of admission criteria that shall include, at a minimum, the following information regarding the resident population: a. Nature and extent of disabling condition(s) served; and b. Restrictions (if any). (1) The statement of admission criteria shall include a statement that no otherwise qualified applicant shall be denied admission to the residence solely on the basis of race, creed, color, religion, sexual orientation, or national	S 230	RECEIVED MAR 0 1 2023 FACILITIES REGULATION ***S 230*** *During an observation on 1/12/2023 Resident #1's medical chart reveals a Recent hospice admit on 9/7/2022, noting "oxycodone" (a controlled substance) Nurse to administer liquid –5mg by mouth every 4 hours.* *Scheduled II medications will only be scheduled "During Nursing hours only" If a scheduled II Medication is needed around the clock the Family will be informed that they or other Family designee will need to come to the Facility to administer them.*	

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
EXECUTIVE DIRECTOR		2/21/2023

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S 230	Continued From page 1 origin. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined the residence failed to provide a scheduled nurse to administer controlled substance medication to a resident PRN (as needed) on the 11 PM-7 AM shift for 1 out of 4 sample residents who require assistance with medication administration, ID #2. Findings are as follows: Record review on 01/12/2023 at approximately 2:00 PM of the staffing schedule revealed there is a Certified Medication Technician (CMT) scheduled in the building from 7 AM-11 PM, and the Registered Nurses (RNs) or Licensed Practical Nurses (LPNs) are typically in the residence from 7 AM-11 PM daily. Record review of Resident ID #1's medical chart reveals a hospice admit date of 09/07/2022. Record review of hospice medication list printed on 09/2022 reveals "Oxycodone [a controlled substance] Nurse to administer Oxycodone Liquid-5mg [milligram] by mouth every 4 hours as needed for pain." During a surveyor interview on 01/12/2023 at approximately 3:30 PM, the Executive Director acknowledged this resident has a PRN order for a controlled substance, and there is no qualified staff scheduled at all times to administer the medications.	S 230	*The wellness director or designee will review all Residents that are currently receiving schedule II Medications to ensure the orders are in place and in compliance.* *The Wellness Director will report her audits to the Executive Director in her Monthly Wellness Directors report due at the end of each month, the findings will be reviewed at QA, and any recommendations to be implemented, ongoing for 90 days or until otherwise recommended. The Wellness Director will be responsible for the compliance.*	*2/21/2023*
S 375	Residency Requirements 2.4.16(F) Resident Assessment/Service Plans	S 375		

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S 375	Continued From page 2	S 375		2/21/2023

DTP 3/3/23

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;
(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.

S 375 Upon the sample review on 1/12/2023, its was found that Resident # 1 and 2 nurse reviews were not Completed up to standards or timely.

Residents will be assessed annually and with any Change of condition. Residents will have a Complete nurse review Annual, every 90 days or COC.

A complete audit of all Residents charts will be conducted for updating and to ensure Regulatory compliance by 2/21/2023.

The Wellness Director will report the compliance To the Quarterly QA meeting.
The Wellness Director will be responsible for the compliance.

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(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 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 complete nurse reviews every 90 days as required for 2 of 4 sample residents reviewed, ID # 1 and 2.

Findings are as follows:

1. Record review revealed Resident ID #1 moved into the residence in October of 2020. S/he has diagnosis including generalized muscle weakness.

Record review revealed the resident had a ninety-day nurse review on 1/12/2021 and the last review on 12/13/2022. Further record review failed to reveal evidence that a 90-day nurse review was completed every 90 days as required.

2. Record review revealed Resident ID #2 moved into the residence in February of 2017. S/he has a diagnosis including Alzheimer's disease.

Record review revealed the resident had a ninety-day nurse review on 05/23/2022 and 08/23/2022. Record review of the resident reveals a medical decompensation resulting in a cancer diagnosis and admittance to hospice on

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S 375	Continued From page 4 09/07/2022. The nurse reviews failed to accurately reflect the resident's medical status. During a surveyor interview on 01/12/2023 at approximately 2:40 PM with the Executive Director, he was unable to provide evidence that the nurse reviews were completed every 90 days as required for Resident ID #1. Additionally, he was unable to provide evidence Resident ID #2's nurse reviews accurately reflect his/her medical status.	S 375		2/21/2023
S 390	Residency Requirements 2.4.16(G)(3) Resident Assessment/Service Plan 2.4.16 (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 the residence failed to review the service plan each time a resident's condition changes significantly, and the plan accurately reflects the residents are receiving outside services for 3 of 4 sample residents reviewed, ID #s 1, 2, and 3. Findings are as follows: 1. Record review revealed Resident ID #1 moved into the residence in October of 2020. S/he has diagnosis including generalized muscle weakness.	S 390	***S 390*** *Residents # 1,2,3 was identified to have Orders for outside services in place as directed.* *Our Wellness Department has completed a complete audit of all residents receiving outside services to reflect compliance.* *All outside services will be documented on the Residents service plan. To be noted the start of Service type of service (PT, OT, ST), how many times per week and discharge date.* *Wellness staff has retrained staff on the policy and procedure and updating service plans when outside services are provided, service plans to be updated to reflect changes effective 2/17/2023.*	

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S 390	Continued From page 5 Record review revealed Resident ID #1 received outside services for skilled nursing service for wound care, Physical Therapy, and Occupational Therapy from September 2022 through December 2022. Record review of the resident's service plans dated 9/12/2022 and 10/12/2022 failed to reveal evidence that the resident was receiving the above-mentioned outside services. 2. Record review revealed Resident ID #2 moved into the residence in February of 2017. S/he has a diagnosis including Alzheimer's disease. Record review revealed Resident ID #2 received outside services for skilled nursing service for wound care from June 2022 through July 2022. Record review of the resident's service plans dated 02/24/2022 and 09/13/2022 failed to reveal evidence that the resident was receiving the above mentioned outside services. 3. Record review revealed Resident ID #3 moved into the residence in October of 2021. S/he had diagnoses including lung cancer, history of falls, and muscle weakness. Record review revealed Resident ID #3 received outside services for Physical therapy with a start of care dated of 10/07/2022 to present and Occupational Therapy with a start date of 10/13/2022 to present. Record review of the resident's service plan dated 08/23/2022 and 10/17/2022 failed to reveal evidence that the resident is receiving the above-mentioned outside services.	S 390	*The Wellness Director shall construct an assessment Schedule for all residents to ensure timely assessments And reviews.* *The Wellness director or designee will monitor this For the next three months to ensure outside services Is listed for those receiving services, and will be Reported to the QA committee.* *The Wellness Director will be responsible for the Compliance.*	

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S 390	Continued From page 6 During an interview on 01/12/2023 at approximately 2:40 PM with the Executive Director, he acknowledged the above-mentioned residents received outside services. He further acknowledged that the residents' service plans did not accurately reflect the outside services the residents are receiving.	S 390		*2/21/2023*
S 490	Residential Care Services 2.4.21(C) Dietetic Services DTP 3/3/23 2.4.21 (C) Dietetic Services C. The food service in each residence shall comply with the appropriate requirements of R.I. Gen. Laws Chapters 21-27 and 21-31, Rhode Island Food Code (Part 50-10-1 of this Title), and such other applicable statutory or regulatory provisions. This Requirement is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined that the residence failed to comply with the appropriate requirements of the Rhode Island Food Code in the main kitchen. Findings are as follows: 1. Section 4-601.11 of the Rhode Island Food Code requires that "... (C) Non FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris." During a surveyor observation of the main kitchen in the presence of the Food Service Director, Staff A, on 01/12/2023 at approximately 9:15 AM,	S 490	***S 490 # 1*** *During an observation on 1/12/2023* *The hood compartments above the stove* *and cooking line had an accumulation of substance* *Outlined.*	

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S 490	Continued From page 7 the hood compartment above the stove was observed with a heavy accumulation of black substance on 3 of the 4 hood compartments and clear yellow dripping substance was observed from 2 of the 4 hood compartments above the stove. 2. According to the Rhode Island Department of Health "Food Code" dated 2018, "'Time/temperature control for safety food' means a FOOD that requires time/temperature control for safety (TCS) to limit pathogenic microorganism growth or toxin formation ... TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is cooked to a temperature and for a time specified under §§ 3-401.11 3-401.13 and received hot shall be at a temperature of 57 °C (135 °F) or above ... Except as specified under (B) and in (C) and (D) of this section, raw animal FOODS such as EGGS, FISH, MEAT, POULTRY, and FOODS containing these raw animal FOODS, shall be cooked to heat all parts of the FOOD to a temperature and for a time that complies with one of the following methods based on the FOOD that is being cooked: ... 74 °C (165°F) or above for 15 seconds for POULTRY, BALUTS, wild GAME ANIMALS as specified under Subparagraphs 3-201.17(A)(3) and (4), stuffed FISH, stuffed MEAT, stuffed pasta, stuffed POULTRY, stuffed RATITES, or stuffing containing FISH, MEAT, POULTRY, or RATITES ... 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 °C (135 °F) or above, except that roasts cooked to a	S 490	*A new heavy duty "weekly" cleaning chart will be devised To meet the following standards for equipment, and all Kitchen staff to be in serviced and reeducated on the safety And regulation set forth by 2/19/2023.* *A new Hot/Cold food holding log will be implemented To ensure all holding items for service meet the proper requirements set forth, all Chef's and Kitchen staff to be Re-educated and In-serviced on the systematic change by 2/19/2023* *The culinary Director, Dining Room Manager, or designee Will continuously monitor the weekly systematic change and report on any inconsistencies and the corrective action in the Monthly Audit.* *The Executive Director and / or HCSG Regional will also provide Random audits as part of this process.* *The findings and recommendations will be reviewed as part of Quality Assurance / Safety for 3 months Or until the committee is satisfied with the outcome.*	

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S 490	Continued From page 8 temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54 °C (130 °F) or above; P or (2) At 5°C (41°F) or less..." During a surveyor observation and temperature testing of food on the steam table in the main kitchen in the presence of Staff A, on 01/12/2023 at approximately 11:45 AM revealed the following food temperature: - Fried chicken: 120-130 °F - Diced squash and turnip 110 °F During a surveyor interview with Staff A, on 01/12/2023 at approximately 9:20 AM and at 11:45 AM, she acknowledged the hood compartments above the stove had a heavy accumulation of black substance and clear yellow dripping substance. Additionally, she acknowledged the above-mentioned food temperature did not reached the required temperature range and that the above-mentioned food has been served to residents.	S 490	***S 490 #2*** *During a observation taken place at 11:45a, Testing of food temperatures to be prepared and held In a steamtable for services noted to be not at proper serving / holding temperatures per guidelines set forth.* *A new heavy duty "weekly" cleaning chart will be devised To meet the following standards for equipment, and all Kitchen staff to be in serviced and reeducated on the safety And regulation set forth by 2/19/2023.* *A new Hot/Cold food holding log will be implemented To ensure all holding items for service meet the proper requirements set forth, all Chef's and Kitchen staff to be Re-educated and In-serviced on the systematic change by 2/19/2023* *The culinary Director, Dining Room Manager, or designee Will continuously monitor the weekly systematic change and report on any inconsistencies and the corrective action in the Monthly Audit.* *The Executive Director and / or HCSG Regional will also provide Random audits as part of this process.* *The findings and recommendations will be reviewed as part of Quality Assurance / Safety for 3 months Or until the committee is satisfied with the outcome.*	