

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415054	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER South Kingstown Nurs. & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 2115 South County Trail West Kingston, RI 02892	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on clinical record review and staff interview, the facility failed to ensure residents were free from significant medication errors for 1 of 3 residents reviewed. Resident ID #1 was inadvertently administered multiple medications prescribed for his/her roommate, Resident ID #2. The medications included two antihypertensives (a medication prescribed to treat high blood pressure), an antidiabetic (a medication prescribed to lower high blood sugar), an antiplatelet (a medication prescribed to prevent blood clots from forming), an antiparkinsonian agent (a medication prescribed to treat Parkinson's Disease), an antidepressant (a medication prescribed to treat depression), a multivitamin, and two additional vitamins. As a result of this error, Resident ID #1 required hospitalization for hypotension (low blood pressure). Review of a facility reported incident submitted to the Rhode Island Department of Health on 2/13/2026 alleges that Resident ID #1 was inadvertently administered medications intended for another resident and s/he was subsequently transferred to the hospital after a change in condition. Resident ID #1 was admitted to the hospital with hypotension. According to the facility policy titled, Medication Administration Safety Program (MASP) - Safety Guidelines, states in part, .2. The same person preparing the doses for administration must administer the medication.4. Prior to actually giving the resident the medication(s), the licensed staff member must confirm the resident's identity. Record review revealed Resident ID #1 was admitted to the facility in January of 2026 with diagnoses including, but not limited to, orthostatic hypotension (a rapid sudden drop in blood pressure when rising from a sitting or lying position), autonomic nervous system disorder (a condition where the nerves that regulate body functions such as blood pressure heart rate and temperature, fail to function properly), and thrombocytopenia (lower than normal level of platelets in the blood which can lead to bleeding). Record review revealed that Resident ID #2 was admitted to the facility in July of 2025 with diagnoses including, but not limited to, Parkinson's Disease (a progressive neurodegenerative disorder affecting the central nervous system), diabetes mellitus (high blood sugar from the body's inability to produce insulin), high blood pressure, major depressive disorder, and coronary artery disease (a condition of the heart where plaque buildup narrows the arteries). During a surveyor interview on 2/16/2026 at 11:26 AM with Registered Nurse (RN), Staff A, she revealed that on 2/12/2026 she was training a newly hired nurse, Licensed Practical Nurse (LPN), Staff B, to administer medications during the morning medication pass. Staff A further revealed that after preparing each of Resident ID #2's medications at the medication cart with Staff B, she instructed Staff B to administer the prepared medications to Resident ID #2. Staff B went into the resident's room and then came back to the medication cart where Staff A had prepared Resident ID #1's medications. Staff A and B went back into Resident ID #1 and ID #2's room to administer the medications prepared by Staff A, to Resident ID #1 and at that time Staff B revealed to Staff A that she had administered Resident ID #1 the medications that were intended for Resident ID #2. Additionally, Staff A revealed that she prepared the following medications that were administered to Resident ID #1 in error: -Lisinopril 10 milligram</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 415054	Facility ID: 415054 If continuation sheet Page 1 of 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415054	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER South Kingstown Nurs. & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 2115 South County Trail West Kingston, RI 02892	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>(mg) (antihypertensive)-Metoprolol Succinate extended release 50 mg (antihypertensive)-Plavix 75 mg (antiplatelet) -Sinemet 25-100 mg (antiparkinsonian agent)-Venlafaxine 37.5 mg (antidepressant) -Metformin 1,000 mg (antidiabetic) -Daily multivitamin 1 tablet -Folic acid 1 mg (vitamin)-Vitamin D3 1000 units (vitamin) During a surveyor interview on 2/16/2026 at 11:57 AM with LPN, Staff B, she revealed that on 2/12/2026 RN Staff A was training her to administer medications during the morning medication pass. Staff B further revealed that Staff A was reviewing each medication that she was preparing for Resident ID #2 with her, and that she was watching Staff A and also viewing the electronic medication record. Staff A then handed her the cup with the medications prepared for Resident ID #2 and instructed her to administer the medications to Resident ID #2. Staff B further revealed that she went into the residents' room and proceeded to identify both Resident ID #1 and Resident ID #2, and then administered the medications intended for Resident ID #2 to Resident ID #1. Staff B returned to the medication cart to meet Staff A, who had prepared Resident ID #1's medications for administration. Staff B re-entered the residents' room with Staff A to administer Resident ID #1 his/her medications and it was at that time that Staff B informed Staff A that she had administered Resident ID #1 the medications that were intended for Resident ID #2. Record review revealed the following: A nursing progress note dated 2/12/2026 at 12:44 PM, authored by Staff A revealed the resident's blood pressure was noted at 99/61 (normal blood pressure reading 120/80) immediately after the error was identified, the physician was notified and ordered Resident ID #1 to receive his/her medication, Midodrine (a medication prescribed to treat low blood pressure). A subsequent blood pressure was obtained after the Midodrine medication was administered, and the results were 104/60. A nursing progress note dated 2/12/2026 at 3:21 PM, authored by Staff A, revealed Resident ID #1 had a blood pressure of 78/40, the physician was notified and ordered for Resident ID #1 to receive Midodrine 10 mg, one time, STAT (immediately). A subsequent blood pressure was obtained approximately 1 hour later, and the results were 87/48. A nursing progress note dated 2/12/2026 at 5:10 PM, authored by Staff A, revealed Resident ID #1's blood pressure was 63/37 and s/he was now pale and weak. The physician was notified, and an order was obtained to transfer the resident to the hospital. A nursing progress note dated 2/12/2026 at 9:05 PM revealed Resident ID #1 was admitted to the hospital with a diagnosis of hypotension (an abnormally low blood pressure). Record review of the hospital continuity of care documentation revealed the Resident ID #1 arrived at the Emergency Department (ED) via EMS (emergency medical services) transport on 2/12/2026, where s/he presented with a blood pressure reading of 80/60, dizziness, and lightheadedness. The document indicated that s/he was administered an intravenous (IV) fluid bolus during EMS transport prior to his/her arrival to the ED. Additionally, the record indicated that his/her blood pressure was monitored, and that Resident ID #1 required additional IV fluids for systolic (the top number of a blood pressure reading that measures the pressure in the arteries when the heart muscle contracts) blood pressure readings in the 80's. During a surveyor interview on 2/16/2026 at 9:48 AM and 10:38 AM with the Director of Nursing Services, she acknowledged that Resident ID #1 inadvertently received Resident ID #2's medications on 2/12/2026, and that Resident ID #1 subsequently became hypotensive, and was transferred to the hospital where s/he was admitted with hypotension. As a result of this survey, it has been determined that Resident ID #1 was placed at risk for serious harm, injury, impairment or death due to Staff B's failure to identify the correct resident prior to administering medications. As a result of this failure, Resident ID #1 exhibited adverse effects from receiving the medications that were not prescribed to him/her. Resident ID #1 was transferred to an acute care hospital, required interventions and was subsequently admitted .</p>		