| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 415076 | A. Building<br>B. Wing | 06/18/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| John Clarke Senior Living | 600 Valley Road<br>Middletown, RI 02842 |

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) |
|---|---|
| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interview, and staff interview, the facility failed to ensure that residents were free from significant medication errors for 1 of 1 resident reviewed, Resident ID #1. Specifically, the facility administered 50 units of short-acting insulin to the resident instead of the prescribed 50 units of long-acting insulin. This medication error resulted in the resident receiving a medication with a substantially different onset, peak, and duration of action than ordered. The facility's failure to administer the medication as prescribed placed the resident at immediate risk for serious hypoglycemia, loss of consciousness, hospitalization, or death. The deficient practice created a situation in which serious injury, serious harm, serious impairment, or death was likely to occur and therefore constituted Immediate Jeopardy to resident health and safety. Findings are as follows:Review of a community reported complaint submitted to the Rhode Island Department of Health on 6/4/2026, alleging that Resident ID #1 was administered the wrong insulin.Review of the facility policy titled, Medication Administration states in part, .Ensure that the six rights of medication administration are followed: Right resident, Right drug, Right dosage.Right route.Right time.Right documentation.Review MAR [Medication Administration Record] to identify medication to be administered.Compare medication with MAR to verify resident name, medication name.dose.Record review revealed the resident was admitted to the facility in March of 2026 with a diagnosis including, but not limited to, type 2 diabetes mellitus (a metabolic condition when the body cannot use insulin correctly and sugar builds up in the blood).Record review of an admission Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 13 out of 15 indicating the resident's cognition is intact.Record review revealed the following physician orders:- NovoLog (a short-acting insulin used to control mealtime blood sugar spikes and begins working within 5-10 minutes) pen-injector 100 unit/milliliter (U/ML) Inject as per sliding scale: if 200 - 249 = 2; 250 - 299 = 4; 300 - 349 = 6; 350 - 399 = 8; 400 - 449 = 10, given before meals for diabetes with a start date of 3/18/2026. - Novolog pen-injector 100U/ML, inject 6 units one time a day in the morning with a start date of 5/23/2026.- Tresiba (a long-acting insulin that is taken once a day that starts to work several hours after administration and works evenly for 24 hours to lower sugar in the blood) 200 U/ML, inject 50 units at bedtime for type 2 diabetes with a start date of 5/22/2026.Record review of the June 2026 MAR revealed on 6/2/2026 the Tresiba insulin order was signed off with a chart code of 5 indicating the insulin was held and to reference the progress notes.Record review of a nursing progress note dated 6/2/2026 at 9:50 PM revealed a medication error had occurred at 8:15 PM resulting in the resident receiving 50 units of Novolog instead of the scheduled 50 units of Tresiba, as ordered. Further review of the progress notes revealed the attending physician was notified of the error, and new orders were obtained to monitor for signs and symptoms of hypoglycemia (low blood sugar) check his/her blood sugar every 20 minutes for 3 hours and hourly thereafter. Additionally, the resident was administered 240 ML of orange juice for prevention of hypoglycemia and cookies.Additional record review of a nursing progress note dated 6/2/2026 at 10:28 PM revealed the physician had called the facility to check on the resident and was informed that the resident's blood sugar was 175 at that time after s/he had been given 240 ML of orange juice and a cookie.Additional (continued on next page) |

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 |
|---|---|---|

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | record review of an incident report dated 6/2/2026 at 8:15 PM states in part, Incident Description: nurse reported administering Novolog 50 units vs [versus] scheduled Tresiba 50 units.immediately reported to MD [Medical Doctor].error reported to resident at time of occurrence.During a surveyor interview on 6/17/2026 at 10:55 AM with Registered Nurse, Staff A, she stated that on 6/2/2026 she had worked on the unit as one of the nurses with Registered Nurse, Staff B. She stated that Staff B had alerted her on the evening of 6/2/2026 that she had administered Resident ID #1 the wrong insulin. Staff A stated that Staff B had acknowledged that she had administered 50 units of Novolog instead of 50 units of Tresiba to the resident. Staff A further stated that she assisted Staff B in monitoring the resident's blood sugar and gave him/her orange juice while Staff B contacted the physician, Nurse Practitioner (NP), Staff C.During a surveyor interview on 6/17/2026 at 12:55 PM with the resident, s/he acknowledged that the staff had indicated to him/her on 6/2/2026 that s/he had been administered the wrong does of insulin.During a surveyor interview on 6/17/2026 at 1:07 PM with NP, Staff C, she acknowledged that she had been notified by the facility on 6/2/2026 of a medication error involving the administration of the wrong insulin to Resident ID #1. She further stated that she expects staff to adhere to all established medication administration policies and procedures, including verifying the resident's identity and confirming the correct medication prior to administering any medication.During a surveyor interview on 6/17/2026 at 10:47 AM and at 11:40 AM with the Director of Nursing Services (DNS), she acknowledged that on the evening of 6/2/2026 she was notified by Staff B that she had administered the wrong insulin to the resident. Additionally, the DNS acknowledged that Staff B had notified her that the resident had been administered 50 units of Novolog in error instead of 50 units of Tresiba, as ordered.During a surveyor interview on 6/18/2026 at 9:13 AM with Staff B, she acknowledged that on the evening of 6/2/2026 she administered 50 units of Novolog to the resident instead of the prescribed 50 units of Tresiba. Staff B stated that she realized the error after administering the insulin and immediately notified Staff A and NP, Staff C. She further acknowledged that she did not verify the type of insulin prior to administration.As a result of the facility's failure to ensure that medications were administered in accordance with facility policy and accepted standards of practice, Resident ID #1 received the wrong medication. Specifically, the facility failed to confirm the correct medication prior to administration, resulting in Resident ID #1 receiving 50 units of a short-acting insulin (Novolog) instead of the prescribed 50 units of a long-acting insulin (Tresiba). Consequently, the resident required continuous monitoring for hypoglycemia following the medication error. This deficient practice placed the resident at risk for serious injury, harm, impairment, or death and had the potential for such outcomes to occur. |