STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415076	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John Clarke Senior Living	600 Valley Road 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on surveyor observation, clinical record review, and staff interview, the facility failed to maintain an infection control program to help prevent the transmission of infections related to contact precautions (an infection control intervention designed to reduce the transmission of multidrug-resistant organisms in nursing homes) and standard precautions (the minimum infection prevention practices applied to all patients in all healthcare settings, at all times, to protect healthcare workers and patients from the transmission of infectious agents, regardless of the patient's infection status) for 2 of 2 residents reviewed, Resident ID #'s 61 and 19.Findings are as follows: 1. Record review of an undated facility policy titled Transmission-Based (Isolation) Precautions states in part .It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission.'Contact precautions' refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident environment.The facility will use standards approaches as defined by the CDC[Centers for Disease Control and Prevention], for transmission-based precautions.contact.If sharing noncritical equipment between residents, the equipment will be cleaned and disinfected following manufacturer's instructions .According to Infection Control Assessment and Response (ICAR) Tool for General Infection Prevention and Control (IPC) Across Settings.Wound Care Facilitator Guide from the Centers for Disease Control and Prevention, last revised on 1/27/2023, states in part, .Maintain separation between clean and soiled equipment to prevent cross contamination .Any unused disposable supplies that enter the patient/resident's care area should remain dedicated to that patient/resident or be discarded. They should not be returned to the clean supply area. If supplies are dedicated to an individual patient/resident, they should be properly labeled and stored in a manner to prevent cross-contamination or use on another patient/resident (e.g., in a designated cabinet in the patient/resident's room) .Multidose topical wound care medications, such as creams, sprays and ointments, should be dedicated to an individual patient/resident.Containers entering patient/resident care areas should be dedicated for single-patient /resident use or discarded after use .Record review revealed that Resident ID #61 was admitted to the facility in April 2026 with diagnoses including, but not limited to, Methicillin-resistant Staphylococcus aureus (MRSA, a strain of Staphylococcus aureus resistant to methicillin and related beta-lactam antibiotics) and an infection of the left knee prosthesis (an artificial knee joint).Further record review revealed a physician's order dated 4/5/2026 for contact precautions to be implemented every shift due to MRSA involving the left lower extremity (LLE) and nares. Additional record review reveaaled the resident receives daily wound care treatment to the buttocks and LLE.During a continuous surveyor observation on 4/9/2026 from 10:10 AM to 10:29 AM, Registered Nurse, Staff A, was observed providing care in the resident's room. Upon exiting, Staff A placed the following items on top of the medication cart without cleaning and disinfecting them per manufacturer's instructions:-A case containing a stethoscope, blood pressure cuff, and pulse oximeter (used to measure heart rate and oxygen saturation)-One eight-ounce bottle of wound cleanser spray-One roll of white tapeDuring a surveyor interview at 10:37 AM on 4/9/2026, Staff A acknowledged that Resident ID #61 is positive for MRSA in both the wound and nares and acknowledged the physician's order for (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contact precautions.A subsequent observation at 10:48 AM revealed Staff A placed the wound cleanser and tape into the medication cart and then entered another resident's room (who was not on contact precautions) with the same vital signs equipment case. The case was placed on that resident's bedside table. The surveyor intervened prior to Staff A obtaining vital signs using the contaminated equipment.During a follow-up interview immediately after the observation, Staff A acknowledged that the vital signs equipment had been taken from a contact precautions room into another resident's room without prior disinfection and confirmed it should have been cleaned before reuse. Staff A also acknowledged placing wound care supplies used for Resident ID #61 into the general wound care supply within the medication cart, which is utilized for multiple residents.During an interview at 12:16 PM on 4/9/2026, the Director of Nursing Services (DNS) stated that equipment used for residents on contact precautions should be dedicated to single-resident use or appropriately disinfected prior to use with other residents. The DNS further stated that wound care supplies for residents on contact precautions are expected to be designated for individual use.2. Record review of the Center for a Disease Control and Prevention guideline titled Clinical Safety: Hand Hygiene for Healthcare Workers dated February 27, 2024, states in part, .If your task requires gloves.change gloves and clean hands.before exiting a patient [resident] room.Record review revealed Resident ID #19 was admitted to the facility in March 2026 with a diagnosis including, but not limited to, type 2 diabetes mellitus (a condition in which the body is unable to properly use or produce sufficient insulin, resulting in elevated blood glucose levels). Further review revealed a physician's order dated 3/18/2026 for NovoLog insulin to be administered subcutaneously (under the skin) via a pen injector in accordance with a sliding scale (a method of insulin dosing based on pre-meal blood glucose levels).During a surveyor observation of Registered Nurse, Staff A, was administering medications on 4/9/2026 at 11:51 AM. She donned (applied) gloves and obtained the resident's blood glucose using a lancet. After applying a drop of blood to the test strip and obtaining the reading, Staff A placed a 2x2 gauze on the resident's finger and exited the room without removing gloves or performing hand hygiene. Staff A then disposed of the lancet and test strip in a sharp's container, reached into her pocket to retrieve keys, touched the top and second drawers of the medication cart, and handled a container of multi-use disinfectant wipes prior to removing gloves or performing hand hygiene.Staff A subsequently applied new gloves and administered NovoLog insulin via injection. She then stepped into the doorway without removing gloves or performing hand hygiene and disposed of the used needle in the sharp's container. Staff A again reached into her pocket for keys, touched the medication cart drawer, and returned the insulin pen to the cart prior to removing gloves or performing hand hygiene.During a surveyor interview immediately following the observation, Staff A acknowledged failing to remove her gloves and performing hand hygiene after obtaining the blood glucose reading and administering the insulin, prior to touching her keys and the medication cart. She further stated that it is her usual practice not to remove gloves during these tasks, revealing that disinfectant wipes are stored in a locked medication cart.During surveyor interviews conducted on 4/9/2026 at 2:39 PM and 4/10/2026 at approximately 12:45 PM, the Director of Nursing Services stated that staff are expected to remove gloves and perform hand hygiene after disposing of the lancet and test strip and prior to exiting the resident's room.