

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2025
NAME OF PROVIDER OR SUPPLIER St Antoine Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 10 Rhodes Avenue North Smithfield, RI 02896	

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 0756</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>46715</p> <p>Based on record review and staff interview, it has been determined that the facility failed to develop and maintain policies and procedures for the facility to act on pharmacy identified irregularities marked as Clinical Priority for 1 of 1 resident reviewed for the use of Clozapine (Clozaril, an atypical antipsychotic medication prescribed for treatment-resistant schizophrenia, recurrent suicidal behavior in schizophrenia), Resident ID #1.</p> <p>Findings are as follows:</p> <p>Review of an article published by the National Library of Medicine, nlm.nih.gov dated 7/1/2019 reveals that abrupt discontinuation of Clozapine has the risk to cause seizures, rebound psychosis, cholinergic rebound (profuse sweating, headache, nausea, vomiting, and diarrhea), serotonin syndrome (agitation, insomnia, high blood pressure, rapid heart rate), and catatonia (a neuropsychiatric syndrome characterized by abnormal movements and behaviors).</p> <p>Review of a community reported complaint submitted to the Rhode Island Department of Health on 3/3/2025 alleged that Resident ID #1 had his/her psychiatric medication stopped without a physician's order and subsequently was admitted to the hospital on 2/3/2025.</p> <p>Record review revealed that Resident ID #1 was readmitted to the facility in December of 2024 with diagnoses including, but not limited to, Alzheimer's disease and schizophrenia.</p> <p>Record review revealed that the resident was readmitted to the facility from the hospital on 12/20/2024 with the following medication order:</p> <p>- Clozapine (antipsychotic, Clozaril) 400 milligrams (mg) at bedtime for 30 days</p> <p>Review of the January 2025 Medication Administration Record (MAR) revealed that the above noted medication had a discontinue date of 1/19/2025, due to the hospital order being for 30 days rather than ongoing.</p> <p>Further review of the MAR revealed that the resident did not receive the above ordered medication for 11 days.</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
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<p>F 0756</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of a Pharmacy Consultation Report dated 1/28/2025 revealed, Clinical Priority Recommendation: Prompt Response Requested .Should the resident still be receiving a bedtime dose of Clozaril? Additional review revealed that Nurse Practioner (NP), Staff A, signed this recommendation on 2/3/2025 with a note stating, Resident should continue Clozaril per order .</p> <p>Review of a progress note dated 2/3/2025 states in part, Resident continues with suicidal ideation, medication refusal, and self-injurious behaviors. [S/he] was found in a geri-chair with a blanket over [his/her] face attempting to induce vomiting by shoving [his/her] fingers down [his/her] throat. When asked why [s/he] was trying to make [her/himself] vomit, [s/he] stated [s/he] was trying to get the toxins out. [S/he] was also found to have toilet paper stuffed in both [his/her] ears and was attempting to swallow tissues to absorb the toxins. Resident refused all medications this evening, despite reinforcement .Resident declining, harmful to [him/herself] and unable to safely remain at facility without 1:1 supervision .</p> <p>Record review revealed that the resident was inpatient on the psychiatric unit at the hospital from 2/3/2025 until 3/6/2025.</p> <p>During a surveyor interview on 3/20/2025 at 10:09 AM with Staff A, she revealed that the Clozaril should have continued as ordered. Additionally, she revealed that the 30 day stop date was put in place in error. The NP further acknowledged that she signed the pharmacy recommendation dated 1/28/2025 on 2/3/2025 the same day that the resident had been transferred to the hospital.</p> <p>During a surveyor interview on 3/20/2025 at 11:00 AM with Registered Nurse, Staff B, she revealed that when the pharmacy does a review the nurses on the unit receive the recommendations in a folder for the providers to sign. Per Staff B, there is no system in place to highlight priority recommendations that require a prompt response.</p> <p>During a surveyor interview on 3/20/2025 at 11:16 AM with the Director of Nursing Services (DNS), she revealed that the pharmacy recommendations marked as Clinical Priority should have been reviewed with the provider within 24 hours of the date that the recommendation was made. The DNS was unable to provide evidence that the irregularity report was acted upon within 24 hours of the 1/28/2025 recommendation date.</p> <p>The facility's failure to have a system in place to ensure that pharmacy reports that require a prompt response are acted upon accordingly, places all of the facility's residents at risk for serious injury, serious harm, serious impairment or death.</p> <p>Cross reference F-760</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>46715</p> <p>Ensure that residents are free from significant medication errors.</p> <p>Based on record review and staff interview it has been determined that the facility failed to keep all residents free from significant medication errors for 1 of 3 residents reviewed, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Review of a policy titled Medication Reconciliation dated 5/13/2019 states in part, .Medication Reconciliation will occur for each patient/resident upon admission/re-admission or re-entry from the hospital to [Facility] to ensure safe and effective administration of medications .For a patient/resident who was sent to the hospital by [Facility] and is re-entering [Facility] after that hospital stay, the admitting nurse will: Review the Continuity of Care Form and clinical record from the discharging hospital and compare that Continuity of Care Form and clinical record with the medications the patient/resident was receiving prior to the hospitalization .</p> <p>Review of an article published by the National Library of Medicine, nlm.nih.gov dated 7/1/2019 reveals that abrupt discontinuation of Clozapine (Clozaril, an atypical antipsychotic medication prescribed for treatment-resistant schizophrenia, recurrent suicidal behavior in schizophrenia) has the risk to cause seizures, rebound psychosis, cholinergic rebound (profuse sweating, headache, nausea, vomiting, and diarrhea), serotonin syndrome (agitation, insomnia, high blood pressure, rapid heart rate), and catatonia (a neuropsychiatric syndrome characterized by abnormal movements and behaviors).</p> <p>Review of a community reported complaint submitted to the Rhode Island Department of Health on 3/3/2025 alleged that Resident ID #1 had his/her psychiatric medication stopped without a physician's order and subsequently was admitted to the hospital on 2/3/2025.</p> <p>Record review revealed that Resident ID #1 was readmitted to the facility in December of 2024 with diagnoses including, but not limited to, Alzheimer's disease and schizophrenia.</p> <p>Record review revealed that the resident was readmitted to the facility from the hospital on 12/20/2024 with the following medication orders:</p> <ul style="list-style-type: none"> - Clozapine 400 milligrams (mg) at bedtime for 30 days - Trazadone 50 mg at bedtime for 30 days - Folic Acid 1 mg daily for 30 days - Lasix 20 mg daily for 30 days - Potassium Chloride 20 milliequivalents daily for 30 days <p>Review of an Order Summary Report revealed that the resident was receiving all of the above noted medications prior to his/her hospitalization in December of 2024.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Further record review failed to reveal evidence that the facility completed a medication reconciliation upon his/her readmission, including comparing the medications from the hospital, with the medications received prior to hospital admission per the facility's policy. Additionally, the facility failed to further review each medication that indicated a 30-day time frame with the provider and transcribed each ordered medication with a stop date of 30 days without clinical reason.</p> <p>Review of the January 2025 Medication Administration Record (MAR) revealed that the above noted medications had a discontinue date of 1/19/2025, due to the hospital order being for 30 days rather than ongoing. Despite Resident ID #1 being seen by a Psychiatric Practitioner on 1/14/2025 which revealed a recommendation to continue with Clozapine 400 mg and Trazadone 50 mg at bedtime. Additionally, it revealed that the Nurse Practitioner (NP), Staff A, agreed with the recommendations, indicating that the recommendations should have been transcribed as an order.</p> <p>Record review failed to reveal evidence that the end date for the Clozapine and Trazadone were updated for continued administration, as ordered by Staff A.</p> <p>Record review of a progress note dated 1/30/2025 revealed that Resident ID #1 was having increased delusions and paranoia. At that time, a medication review was completed by the nurse, and it was identified that s/he was not receiving his/her prescribed dose of Clozapine 400 mg or Trazadone 50 mg.</p> <p>Further review of the January 2025 MAR revealed that on 1/31/2025 all of the above-mentioned medications were resumed.</p> <p>Review of a progress note dated 2/3/2025 states in part, Resident continues with suicidal ideation, medication refusal, and self-injurious behaviors. [S/he] was found in a geri-chair with a blanket over [his/her] face attempting to induce vomiting by shoving [his/her] fingers down [his/her] throat. When asked why [s/he] was trying to make [her/himself] vomit, [s/he] stated [s/he] was trying to get the toxins out. [S/he] was also found to have toilet paper stuffed in both [his/her] ears and was attempting to swallow tissues to absorb the toxins. Resident refused all medications this evening, despite reinforcement. Resident declining, harmful to [him/herself] and unable to safely remain at facility without 1:1 supervision.</p> <p>Record review revealed that the resident was admitted to the hospital on 2/4/2025 with suicidal ideation, paranoia, visual, olfactory (smell) and auditory hallucinations. S/he was inpatient until 3/6/2025.</p> <p>During a surveyor interview on 3/20/2025 at 10:09 AM with Nurse Practitioner, Staff A, she acknowledged that the resident had been receiving all of the medications noted above prior to his/her hospital admission in December 2024. The NP acknowledged that the orders transcribed with a 30 day stop date upon readmission was an error. Additionally, she revealed that she would have expected the staff to continue the resident's order for Clozapine 400 mg and Trazadone 50 mg, past the 30 days as recommended by the Psychiatric Practitioner and approved by her.</p> <p>During a surveyor interview on 3/20/2025 at 11:16 AM with the Director of Nursing Services (DNS) she acknowledged that the resident's Clozapine, Trazadone, Folic Acid, Lasix and Potassium Chloride were transcribed with a 30 day stop date in error. Additionally, the DNS was unable to provide evidence that a medication reconciliation was completed for the resident per the facility policy. The DNS was unable to provide evidence that the resident was kept free from significant medication errors.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility's failure to conduct a medication reconciliation upon the resident's re-admission to the facility, resulted in the resident not receiving his/her necessary medications. This failure resulted in the resident's transfer and month long admission to an acute hospital for treatment, after experiencing suicidal ideation's and delusions. these failures placed Resident ID #1 at risk for serious injury, serious harm, serious impairment, or death.</p> <p>Cross Reference F 756</p>		