

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024
NAME OF PROVIDER OR SUPPLIER St Clare Home		STREET ADDRESS, CITY, STATE, ZIP CODE 309 Spring Street Newport, RI 02840	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>45263</p> <p>Based on record review and staff interview, it has been determined that the facility failed to review and revise the resident's care plan relative to 2 of 3 residents reviewed for falls, Resident ID #s 1 and 2.</p> <p>Findings are as follows:</p> <p>1. Record review revealed Resident ID #1 was admitted to the facility in June of 2018 and re admitted in August of 2024 with a diagnosis that includes, but is not limited to, a displaced fracture of the base of neck of left femur (thighbone).</p> <p>Record review of a document titled Monthly Falls Tracking revealed s/he had sustained falls on 9/27/2024 and on 10/16/2024.</p> <p>Record review of a care plan that was initiated on 6/10/2024 and revised on 11/13/2024, after it was brought to the Director of Nursing Sevices attention had a focus of the resident having falls on 6/9/2024, 9/27/2024, and 10/16/2024. The care plan interventions failed to be reviewed and revised for the falls that occurred on 6/9/2024 and 9/27/2024.</p> <p>2. Record review revealed Resident ID #2 was admitted to the facility in April of 2024 with a diagnosis that includes, but is not limited to, orthopedic aftercare following a surgical amputation.</p> <p>Record review of a care plan dated 5/20/2024 had a focus of the resident being at risk for falls and sustaining falls on 5/23/2024, 7/27/2024, 9/29/2024, 10/22/2024, and 10/25/2024.</p> <p>Further record review of the care plan failed to reveal evidence that the care plan interventions were reviewed and revised for the above-mentioned falls.</p> <p>During a surveyor interview on 11/13/2024 at approximately 3:00 PM with the Director of Nursing Services, she was unable to provide evidence that the care plans were reviewed and revised for Resident ID #s 1 and 2.</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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>45263</p> <p>Based on record review and staff interview it has been determined that the facility failed to ensure that residents are free of any significant medication error for 1 of 3 residents reviewed, Resident ID #6.</p> <p>Findings are as follows:</p> <p>1. Resident ID #6 was admitted to the facility in April of 2022 with a diagnosis including, but is not limited to, multiple sclerosis (a disease in which the immune system eats away the protective covering of the nerves).</p> <p>Record review of the November Medication Administration Record (MAR) revealed s/he is to receive Methylphenidate HCL (Ritalin, type of medication that is a stimulant that improves focus and impulsive behaviors) oral tablet 30 Milligrams(mg) three times daily.</p> <p>Record review of the MAR revealed a missed dose of Ritalin on 11/7/2024, 11/8/2024, and 11/9/2024.</p> <p>During a surveyor interview on 11/13/2024 at approximately 2:00 PM with a Registered Nurse, Staff A, she revealed the resident did receive a 10:00 AM dose of the medication at approximately 12:00 PM and the 2:00 PM dose at approximately 2:20 PM. Additionally, she revealed the medication was not available for a period of time, as the keys to the medication cart were locked in the cart.</p> <p>Record review of progress notes failed to reveal evidence that the medical provider was notified that the prescribed medication was not administered as ordered on 11/7/2024, 11/8/2024, and 11/9/2024.</p> <p>During a surveyor interview on 11/13/2024 at approximately 2:00 PM with Staff A, she was unable to provide evidence that the medical provider was contacted.</p> <p>During a surveyor interview with the Director of Nursing Services on 11/13/2024 at approximately 3:00 PM, she was unable to provide evidence that the resident did receive the medication at the scheduled times. Additionally, she could not provide evidence the medical provider was made aware of the missed doses of medication.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45263</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to store and label drugs and biologicals in accordance with currently accepted professional principles, for 2 of 3 residents reviewed for medication storage, Resident ID #s 4 and 5.</p> <p>Findings are as follows:</p> <p>Record review revealed the facility policy titled, Medication Labeling and Storage, states in part, .If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items .</p> <p>1. Resident ID #4 was admitted to the facility in September of 2024 with a diagnosis that includes, but is not limited to, pneumonia.</p> <p>Record review of a progress note dated revealed that the resident had expired on [DATE].</p> <p>During a surveyor observation of the nursing medication cart on [DATE] at approximately 2:15 PM with Registered Nurse, Staff A, and in the presence of the Director of Nursing Services (DNS), revealed a blister medication card with 10 tablets of Methylphenidate HCL (Ritalin, a medication that is a stimulant that improves focus and impulsive behaviors) 5 mg (milligrams) with Resident ID #4's name on it.</p> <p>2. Resident ID #5 was admitted to the facility in November of 2024 with a diagnosis that includes, but is not limited to, Alzheimer's disease.</p> <p>Record review of a document titled, 'Medication Error, reads in part, Resident ID #5 was administered 1 tab of Alprazolam (Xanax, an anxiety medication) instead of 1 tab of Lorazepam (also an anxiety medication) on [DATE].</p> <p>Record review revealed there was not a physician's order for Alprazolam for Resident ID #5 at any time during the resident's admission to the facility.</p> <p>During a surveyor observation on [DATE] at approximately 2:00 PM of the nursing medication cart on the [NAME] nursing unit, with Registered Nurse, Staff A, in the presence of the Director of Nursing Services (DNS), a blister medication card with 26 tablets of 0.25mg. Alprazolam with Resident #5 name on it was identified.</p> <p>Surveyor observations revealed medications were not removed from the medication carts per the facility policy.</p> <p>During a surveyor interview on [DATE] at approximately 2:30 PM with the DNS, she acknowledged that the medications for Resident ID #s 4 and 5 should have been destroyed, per facility policy.</p>		