

PRINTED: 04/29/2025  
FORM APPROVED

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  ALR01494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/24/2025
NAME OF PROVIDER OR SUPPLIER  ST CLARE - NEWPORT		STREET ADDRESS, CITY, STATE, ZIP CODE 309 SPRING STREET NEWPORT, RI 02840		
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S 003	Initial Comments  An unannounced complaint/incident investigation survey, ACTS reference numbers 98560, 99825, 99839, 100443, and 100556, was conducted at this residence on 4/23/25-4/24/2025 to determine compliance with state regulations. Deficiencies were identified.	S 003	Received  MAY 06 2025  Facilities Regulation	
S 230	Organization And Management 2.4.13.A Management Of Services  2.4.13 (A/B) Management of Services  A. Each residence shall provide services with adequate professional and ancillary employees and in accordance with applicable state law. Further, the residence shall assure that all services are rendered in a safe and effective manner and consistent with the requirements herein. The residence shall provide all care and services to all residents in accordance with the prevailing community standard of care.  This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to provide care and services in accordance with prevailing community standards of care relative to the notification of a responsible party (RP) for the singular resident reviewed relative to falls, Resident ID #1; following the physician's orders of a singular resident reviewed relative to outside	S 230	Resident #1 - The facility staff will ensure the resident's RP is notified of any incidents involving the resident.  Resident #3 - The resident is currently receiving PT and OT services.  Resident #4 - Right upper arm wounds has resolved.  Resident #5 - Skin tear to left forearm has resolved.  Resident #6 - Facial wound has resolved.  The facility has conducted a full review/audit all incident/accident reports, admissions and or readmissions and after visit reports/COC's for the past month in order to determine the following areas of compliance:  1. Notification of RP, MD or NP for any incident, such as falls, skin tears, resident to resident, etc.  2. Compliance with obtaining, documenting and following physician orders, including COC's for aftercare follow up or outside services.	5/14/2025

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X5) DATE

*Kattand*

*Administrator*

5/6/2025

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S 230	<p>Continued From page 1</p> <p>services, Resident ID #3 and for 3 of 3 residents reviewed for wound care, Resident ID #s 4, 5, and 6.</p> <p>Findings are as follows:</p> <p>R.I. Gen. Laws § 23-17.4-16, "Rights of Residents" states in part, "...Section (xx) To have the resident's responsible person and physician notified when there is: (A) An accident involving the resident that results in injury and required physician intervention..."</p> <p>Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients."</p> <p>Record review of a residence policy, last revised 3/2025, titled "Incident Report" states in part, "...An incident report form should be completed to document what happened...If a resident is involved in any incident, their responsible person must be notified to let them know of the occurrence...All incident reports related to residents will be kept in their records..."</p> <p>Record review of a facility policy, last revised 4/2024, titled "Wound Care" states in part, "...The purpose of this policy is to provide guidelines for simple wound care...Procedure...Verify that there is a physician's order for this procedure...Apply treatments as indicated. Documentation The following information should be signed off/recorded in the resident's medical record: 1. The type of wound care given 2. The date and time the wound care was given 3. The name and title of the individual performing the wound care...All assessment data obtained when</p>	S 230	<p>The policies titled Incident Report and Wound Care were revised and education on these policies was provided to the nursing staff.</p> <p>The Program Director/designee will audit all incident/accident reports, aftercare visit/COC's weekly for four weeks and monthly thereafter to ensure compliance with RP, MD notifications, and physician orders to ensure compliance.</p> <p>Audit findings will be presented to the QAPI committee.</p> <p>The Executive Director is responsible to ensure compliance.</p>	

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S 230	<p>Continued From page 2 inspecting the wound..."</p> <p>1. Record review of a residence reported incident of unknown origin submitted to the Rhode Island Department of Health on 3/7/2025 alleges that Resident ID #1 has a bruise on his/her right arm.</p> <p>Record review revealed ID #1 was admitted to the residence in September of 2024 with diagnoses including, but not limited to, dementia and repeated falls.</p> <p>Record review revealed a progress note dated 3/28/2025 that Resident ID #1 had an unwitnessed fall the previous day 3/25/2025.</p> <p>During a surveyor interview on 4/23/2025 at 10:09 AM with Resident ID #1's RP, s/he indicated that s/he was not made aware by the facility of the resident's fall on 3/25/2025.</p> <p>During a surveyor interview on 4/23/2025 at approximately 12:45 PM with the Executive Director, she acknowledged that Resident ID #1's RP was not notified of the unwitnessed fall on 3/25/2025. Additionally, she indicated the RP should have been notified by the facility.</p> <p>2. Record review revealed ID #3 was readmitted to the residence in February of 2025 with a diagnosis including, but not limited to, a displaced fracture of the left tibia (shin bone).</p> <p>Record review revealed a "Continuity of Care Form", dated 2/13/2025, with a physician's order for physical therapy (PT) and occupational therapy (OT) when the resident was readmitted to the residence.</p> <p>Record review of a "Continuity of Care</p>	S 230		

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S 230	<p>Continued From page 3</p> <p>Consultation and Referral form dated 4/7/2025 revealed a physician's order for PT and OT, as the resident was not receiving these services.</p> <p>Record review failed to reveal evidence that the order for PT was acted upon until 4/10/2025 approximately two months after the initial order was given. Additional record review failed to reveal evidence that the OT order was acted upon until 4/23/2025 approximately seventy days after the initial order was given.</p> <p>3a. Record review revealed ID # 4 was admitted to the residence in January of 2025 with a diagnosis including, but not limited to, dementia.</p> <p>Record review of ID #4's dermatology provider visit notes dated 3/25/2025 and 4/11/2025 revealed that the resident was seen at the dermatologist's office on the above-mentioned dates for treatment of skin cancer of his/her right upper arm. Additional review of the 4/11/2025 visit note revealed, a post visit treatment plan to apply Mupirocin 2% ointment (an antibiotic ointment) twice daily under a clean bandage to the right upper arm.</p> <p>Record review failed to reveal evidence that the above-mentioned visit notes or the physician's order to treat his/her right upper arm wounds was followed.</p> <p>3b. Record review revealed ID #5 was readmitted to the residence in February of 2019 with diagnoses including, but not limited to, dementia and fracture. Additionally, the resident receives hospice services.</p> <p>Record review of ID #5's hospice provider note dated 3/24/2025 revealed s/he was observed with</p>	S 230		

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S 230	<p>Continued From page 4</p> <p>a large skin tear on his/her left forearm. Additional review of the notes revealed a dressing was applied by facility staff to the skin tear wound.</p> <p>Record review failed to reveal evidence that Resident ID #5's physician was notified of the skin tear, that a physician's order was obtained to treat the wound, and the residents skin was assessed and treated appropriately.</p> <p>3c. Record review of a facility reported incident submitted to the Rhode Island Department of Health on 4/15/2025 alleges that Resident ID #7 scratched Resident ID #8 on his/her face.</p> <p>Record review revealed ID #8 was admitted to the residence in May of 2024 with a diagnosis including, but not limited to, dementia.</p> <p>Record review failed to reveal evidence that Resident ID #8's physician was notified of the resident-to-resident incident and the wound to Resident ID #8's face. Further review failed to reveal evidence that a physician's order was obtained to treat the wound to the resident's face after the incident occurred.</p> <p>During a surveyor interview on 4/24/2025 at 12:34 PM with the Nurse Practitioner, the provider for Resident ID #s 4, 5, and 6 she indicated it would be her expectation to have been notified of the wounds for both Resident ID #s 5 and 6, and treatment orders to have been obtained. Additionally, she indicated it would be her expectation that the dermatology visit notes for Resident ID #4 would have been obtained by the facility for her review, and the residence would then obtain treatment orders.</p>	S 230		

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S 230	Continued From page 5  During an interview on 4/25/2025 at 8:26 AM and 1:06 PM, the Director of Operations was unable to provide evidence that a physician's order for wound care was obtained for Resident ID #s 4, 5 and 6. Additionally, she was unable to provide evidence that the physician's orders for OT and PT for Resident ID #3 were acted upon timely.	S 230		
S 310	Residency Requirements 2.4.15.A Resident Records  2.4.15 (A) Resident Records  A. Each residence shall, at a minimum, maintain the following information for each resident:  1. The resident's name;  2. The resident's last address;  3. The name of the person or agency referring the resident to the home;  4. The name, specialty (if any), telephone number, and emergency telephone number of each physician who is currently treating the resident;  5. The date the resident began residing in the home;  6. A list of medications taken by the resident, including dosage, and specific records of medication administration as required by the Department;  a. In residences licensed at the M2 level, if a resident refuses to provide the information cited in § 2.4.15(A)(6) of this Part, this fact shall	S 310  <i>[Handwritten Signature]</i>  5/14/25	Resident #4 - Resident wounds have resolved. Aftervisit notes were obtained from resident's appointments.  Resident #5 - Skin tear to left forearm has resolved.  Resident #6 - Facial wound has resolved.  The facility has conducted a full review/audit all incident/accident reports, admissions and or readmissions and after visit reports/COC's for the past month in order to determine the following areas of compliance are documented in the resident's record:  1. Compliance with obtaining, documenting and following physician orders, including wound care assessments are documented in the resident record.	5/14/2025

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S 310	<p>Continued From page 6</p> <p>be documented in the resident's service agreement.</p> <p>7. Written acknowledgments that the resident has signed and received copies of the rights as provided in R.I. Gen. Laws § 23-17.4-16;</p> <p>8. Information about any specific health problems of the resident, which may be useful in a medical emergency, including diagnostic and/or therapeutic orders;</p> <p>9. A record of personal property and funds which the resident has entrusted to the residence;</p> <p>10. The name, address, and telephone number of a person identified by the resident who should be contacted in the event of an emergency or death of the resident and the name, address, and telephone number of the legal guardian;</p> <p>11. Any other health-related emergency, or pertinent information which the resident requests the residence to keep on record;</p> <p>12. A copy of the initial and periodic assessments described in § 2.4.16 of this Part;</p> <p>13. A copy of the service plan and nurse review as described in § 2.4.16 of this Part;</p> <p>14. A copy of the residency agreement as described in § 2.4.14(C) of this Part.</p> <p>This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to maintain,</p>	S 310	<p>The policy for Resident Record Documentation was revised and education on this policy was provided to the nursing staff.</p> <p>The Program Director/designee will conduct random weekly resident record reviews to ensure compliance with documentation related to wounds, treatment orders and skin assessments.</p> <p>Audit findings will be presented to the QAPI committee.</p> <p>The Executive Director is responsible to ensure compliance.</p>	

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S 310	<p>Continued From page 7</p> <p>at a minimum, information about any specific health problems of the resident, which may be useful in a medical emergency, including therapeutic orders for 3 of 3 sample residents reviewed for wound care, Resident ID #s 4, 5, and 6.</p> <p>Findings are as follows:</p> <p>Record review of a residence policy titled "wound Care" last revised 4/2024 states in part, "...The purpose of this policy is to provide guidelines for simple wound care...Procedure...Verify that there is a physician's order for this procedure...Apply treatments as indicated. Documentation The following information should be signed off/recorded in the resident's medical record: 1. The type of wound care given 2. The date and time the wound care was given 3. The name and title of the individual performing the wound care...All assessment data obtained when inspecting the wound..."</p> <p>1. Record review of a facility reported incident submitted to the Rhode Island Department of Health on 3/10/2025 alleges that Resident ID #4 was struck in the left arm by another resident.</p> <p>Record review revealed ID #4 was admitted to the residence in January of 2025 with a diagnosis including, but not limited to, dementia.</p> <p>Record review of ID #4's dermatologist's office visit notes, dated 3/25/2025 and 4/11/2025, revealed that the resident was seen at the dermatologist's office on the above-mentioned dates for treatment of skin cancer of his/her right upper arm. Additional review of the 4/11/2025 visit notes revealed, a post visit treatment plan to apply Mupirocin 2% ointment (an antibiotic</p>	S 310		

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S 310	<p>Continued From page 8</p> <p>ointment) twice daily under a clean bandage to the right upper arm.</p> <p>Record review failed to reveal evidence that the above-mentioned visit notes were obtained after the resident's appointments; therefore, the residence was not aware of the new order or the resident's current health condition.</p> <p>2. Record review of a facility reported incident submitted to the Rhode Island Department of Health on 4/23/2025 alleges that Resident ID #5 was not assisted with his/her meal.</p> <p>Record review revealed ID #5 was readmitted to the residence in February of 2019 with diagnoses including, but not limited to, dementia and fracture.</p> <p>Record review of ID #5's hospice provider note dated 3/24/2025 revealed s/he was observed with a large skin tear on his/her left forearm. Additional review revealed a dressing was applied to the skin tear wound by facility staff; however, there was no documentation of wound care or assessments of the wound in the resident's record.</p> <p>3. Record review of a facility reported incident submitted to the Rhode Island Department of Health on 4/16/2025 alleges that Resident ID #7 scratched Resident ID #6 on his/her face.</p> <p>Record review revealed ID #6 was admitted to the residence in May of 2014 with diagnoses including, but not limited to, dementia.</p> <p>Record review failed to reveal evidence that a physician's order was obtained for Resident ID #6's face wound. Additionally, there was no</p>	S 310		

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S 310	<p>Continued From page 9</p> <p>documentation of wound care or assessments of the wound in the resident's record.</p> <p>During surveyor interviews on 4/25/2025 at 8:26 AM and 1:08 PM, the Director of Operations was unable to provide evidence that Resident ID #s 4, 5 and 6's records held all information necessary to maintain, at a minimum, information about any specific health problems of the resident, which may be useful in a medical emergency, including therapeutic orders.</p>	S 310		