RI Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALR01311 | A. BUILDING: _____ B. WING _____ | C 05/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ETHAN PLACE | 85 ETHAN STREET WARWICK, RI 02888 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 003 | Initial Comments<br><br>An unannounced complaint/incident investigation survey, ACTS reference numbers 100535 and 100885, was conducted at this residence from 05/27/2025 through 05/29/2025 to determine compliance with state regulations. A deficiency was identified. | S 003 | Received<br>JUN 16 2025<br>Facilities Regulation | |
| S 230 | Organization And Management 2.4.13.A Management Of Services<br><br>2.4.13 (A/B) Management of Services<br><br>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.<br><br>This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to provide care and services in accordance with the prevailing community standard of care relative to administering medications in accordance with written physician's orders for a singular resident reviewed for medication, Resident ID #1.<br><br>Findings are as follows:<br><br>According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states in part, "...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..." | S 230 | S230 Organization And Management<br>Resident ID#1 The resident had outside Services providing [redacted] medication, nurse And I will closely monitor any outside agency to ensure all medications are in-house and have orders that match the emar.<br>Any issues obtaining medication the nurse will be required to follow up with providers.<br>When a resident is repeatedly refusing any services Nurse will follow up with residents about the Importance of following orders.<br>6/18/25 | |

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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| S 230 | Continued From page 1<br><br>Record review of a community reported complaint sent to the Rhode Island Department of Health on 5/19/2025 alleges Resident ID #1 had trouble getting her/his medications for days.<br><br>Record review of Resident ID #1 revealed s/he was admitted to the residence in May of 2023 with diagnoses including, but not limited to: hypertension (HTN, high blood pressure), type 2 diabetes mellitus, and depressive disorder.<br><br>Record review revealed the following physician's orders:<br><br>-Blood sugar (BS) check twice a day, once before breakfast (7 AM) and once in the evening (7 PM).<br><br>-Senna 8.6 mg (milligrams), take one tablet by mouth twice a day, hold for loose stool.<br><br>-Lisinopril 10 mg tablet for HTN, take one tablet by mouth daily.<br><br>-Rybelsus 14 mg tablet for blood sugar control, take one tablet by mouth daily.<br><br>-Venlafaxine ER (extended release) 150 mg capsule for depression/mood, take one capsule by mouth daily.<br><br>Review of the medication administration record revealed the following:<br><br>-In April relative to the 7 AM BS check: 23 out of 30 were refused; relative to the 7 PM BS check, 27 out of 30 were refused.<br><br>-In May relative to the 7 AM BS check: 15 out of 20 were refused; relative to the 7 PM BS check, | S 230 | | |

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| S 230 | Continued From page 2<br>17 out of 20 were refused.<br><br>-Senna not available from 4/16-5/1.<br><br>-Mirtazapine 7.5 mg dose was missed on 4/17, 4/24, 5/5, and on 5/6.<br><br>-Lisinopril dose was missed on 4/19 and not available from 4/26 through 5/3, and another missed dose on 5/18.<br><br>-Rybelsus dose was missed on 4/13 and 4/19 and not available from 5/6 through 5/9.<br><br>-Venlafaxine dose was missed on 4/13 and 4/20 and not available from 5/14 through 5/19.<br><br>The record failed to reveal evidence the physician was notified of medications being refused, missed, or unavailable on the above-mentioned dates.<br><br>During a surveyor interview on 5/27/2025 at 1:00 PM with the Director of Wellness, she acknowledged that the resident did not receive his/her medications per the physician's orders. Additionally, she could not provide evidence that the physician was notified that the resident had not received the above-mentioned medications on the above-mentioned dates and that the resident had been refusing to have his/her blood sugars checked regularly. | S 230 | | |