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 _____	01/16/2026

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

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S 003	Initial Comments An unannounced biennial State Licensure survey and a complaint/incident investigation survey (E34C11, 01/16/2026)were conducted at this residence. Deficiencies were identified relative to the State Licensure survey.	S 003		
S 055	Licensure Requirements 2.4.3 Quality Assurance 2.4.3 Quality Assurance A. In accordance with R.I. Gen. Laws § 23-17.4-10.1, each assisted living residence shall develop, implement and maintain a documented, ongoing quality assurance program. 1. The purpose of this program shall be to attain and maintain a high quality assisted living residence through an on-going process of quality improvement that monitors quality, identifies areas to improve, methods to improve them, and evaluates the progress achieved. 2. Each licensed residence shall establish a quality improvement committee which shall include at least the following: assisted living administrator, registered nurse and a representative of dietary services. 3. The quality improvement committee shall meet at least quarterly; shall maintain records of all quality improvement activities; and shall keep records of committee meetings that shall be available to the Department during any on-site visit. 4. The quality improvement committee shall review and approve the quality improvement plan for the residence at intervals not to exceed twelve (12) months. Said plan shall be available to the	S 055		

Received
FEB 10 2026
Facilities Regulation

2/10/26

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

Stephanie Robey Supervising Administrator 2/10/26

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S 055	Continued From page 1 public upon request. 5. Each assisted living residence shall establish a written quality improvement plan that includes: a. Program objectives; b. Oversight responsibility (e.g., reports to the governing body, QI records); c. Includes methods to identify, evaluate, and correct identified problems; d. Provides criteria to monitor personal assistance and resident services, including, but not limited to: (1) Resident/family satisfaction; (2) Medication administration/errors; (3) Reportable incidents as specified in § 2.4.17 of this Part; (4) Resident falls; (5) Plans of correction developed in response to the Department ' s inspection reports. B. In addition to the requirements of §§ 2.4.3(A) (1) through (5) of this Part, all assisted living residences with a "dementia care" license and/or a "limited health services license" shall also address the following areas in their quality improvement plan: 1. Prevention and treatment of decubitus	S 055		

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S 055	Continued From page 2 ulcers; 2. Dehydration, and nutritional status and weight loss or gain; and 3. Changes in mental or psychological status. 4. Quality improvement documentation shall be kept on file for a minimum of five (5) years. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to establish a written quality improvement plan that included all required components. Findings are as follows: Record review of the written plan failed to describe medication administration and medication errors. Additionally, the plan failed to describe resident falls. During a surveyor interview with the Administrator on 1/16/2026 at approximately 2:00 PM, she could not provide evidence that the quality improvement plan had all of the required components.	S 055	(W) 2/11/26 The Administrator and DON will revise the quality assurance report to include medication errors and resident falls, even if their care none to be reported.	
S 170	Organization And Management 2.4.13.A Administrative Management 2.4.13 (A) Administrative Management A. All licensees shall provide staffing which is sufficient to provide the necessary care and services to attain or maintain the highest	S 170		

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S 170	Continued From page 3 practicable physical, mental and psychosocial well-being of the residents, according to the appropriate level of licensing. At least one (1) staff person who has completed employee training as outlined in § 2.4.12(G) of this Part shall be on the premises at all times. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the facility failed to provide staffing which is sufficient to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the residents, relative to personal care provided by Staff A and B. Findings are as follows: Review of the Nursing Assistants, Medication Aides, and the Approval of Nursing Assistant and Medication Aide Training Programs (216-RICR-40-05-22) regulations under Section 22.4 "Levels of Nursing Assistants," states in part, "...1. Nursing Assistant. A nursing assistant is a paraprofessional trained to provide personal care and related health care and assistance to individuals...and who are residents of or receiving services from health care facilities or agencies licensed by the State, and holds a license as a nursing assistant issued by the Department..." Further review of the regulations under Section 22.5 "General Requirements: Nursing Assistants and Medication Aides" states in part, "...A. No person shall be employed in this State as a nursing assistant or medication aide unless he or she holds a license as a nursing assistant in	S 170		

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S 170	Continued From page 4 accordance with the provisions of the Act and this Part..." Review of a job description titled, "PCA" (Personal Care Attendant) states in part, "...Examples of work Performed: ...To assist residents with the Activities of Daily Living such as; toileting, dressing, bathing..." Review of a facility staff list indicated PCA, Staff A, was hired on 9/8/2025. The list further indicated PCA, Staff B, was hired on 4/14/2020. During a surveyor interview with Staff A on 1/15/2026 at 1:40 PM, she revealed she assists residents with bathing and dressing. During a surveyor interview with Staff B on 1/16/2026 at 8:16 AM, she revealed she assists residents with dressing and showers. During a surveyor interview with a resident on 1/16/2026 at 1:42 PM, he/she revealed that he/she receives assistance with showering and bathing from Staff B. During a surveyor interview with the Administrator on 1/16/2026 at approximately 11:00 AM, she acknowledged PCAs do not hold an active Rhode Island CNA license and provide personal care to residents as needed.	S 170	S170 effective immediately, the facility ceased assigning PCAS to provide hands on personal care (bathing, dressing, & toileting) All personal care tasks are now provided only by licensed nursing staff 2/11/26	
S 295	Organization And Management 2.4.14.J Management Of Services 2.4.14 (J) Smoking Policy 1. If the residence permits smoking, it shall have a policy that includes the following:	S 295		

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S 295	Continued From page 5 a. Location of designated smoking area(s) separate from the common area; b. Prohibition of smoking in any area other than the designated area(s); c. Adequate ventilation in smoking areas; d. Assessment (upon admission, quarterly, and when a significant change in function occurs) of all residents that smoke to ensure ~~safe~~ smoking capabilities. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to follow their policy relative to smoking and failed to complete a smoking assessment upon admission and quarterly for 2 of 2 sample residents reviewed for smoking, Resident ID #s 1 and 2. Findings are as follows: Review of a policy titled, "...1.1 Smoking...1. The smoking areas on the grounds of the Residence include the parking lot only. 2. Residents who smoke will undergo an assessment for their ability to safely smoke as part of their clinical assessment for admission into the residence and as required by RI Department of Health regulations..." During a surveyor interview with the Director of Wellness (DOW) on 1/15/2026 at approximately 9:00 AM, she revealed Resident ID #1 and 2 are smokers.	S 295		

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S 295	Continued From page 6 1) Record review revealed Resident ID #1 moved into the residence in November of 2024 with a diagnosis including, but not limited to, chronic obstructive pulmonary disease. Further record review failed to reveal evidence of a smoking assessment being completed upon admission. Record review revealed a smoking assessment dated 3/8/2025, 6/20/2025, and 12/4/2025. The record further failed to reveal a quarterly assessment for September of 2025. a. During a surveyor observation on 1/16/2026 at 7:30 AM, the resident was outside on a bench in the back of the building smoking, not a designated area per the facility's policy. Following the above observation, Certified Medication Technician, Staff C, observed the resident outside and brought the resident inside and reminded the resident that the parking lot area is the only designated area to smoke. During a surveyor interview with the Administrator following the above observation, we went outside in the back of the building so the Administrator could observe several cigarette butts on the ground near the bench. She acknowledged the cigarette butts on the ground and was unable to provide evidence that the residents are smoking in the designated areas. 2) Record review revealed Resident ID #2 moved into the residence in July of 2025 with a diagnosis including, but not limited to, Type 2 diabetes mellitus.	S 295		

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S 295	Continued From page 7 During a surveyor interview with the DOW on 1/16/2026 at approximately 11:45 AM, she revealed the resident did not come into the residence smoking, s/he began smoking after admission. During a surveyor interview with the resident on 1/16/2026 at approximately 1:15 PM, s/he revealed that s/he smokes about two to three cigarettes per day and has been smoking for several months. Further review of the record failed to reveal any smoking assessments, evaluating the resident's ability to smoke safely. During a surveyor interview with the DOW on 1/16/2026 at approximately 12:15 PM, she could not provide evidence of an initial smoking assessment for both residents. Additionally, she could not provide evidence that Resident ID #1 had a September's smoking assessment and could not provide evidence of any assessments for Resident ID #2.	S 295	S295 Both Resident #1 and #2 have had comprehensive Smoking assessments completed immediately to evaluate their ability to Smoke Safely. Each Residents care plan has been updated to reflect Smoking status, designated Smoking area, and Safety protocols	
S 335	Residency Requirements 2.4.16.A Resident Records 2.4.16 (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;	S 335		

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S 335	Continued From page 8 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 be documented in the resident ' s service agreement. 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; 8. Information about any specific health problems of the resident, which may be useful in a medical emergency, including diagnostic and/or therapeutic orders; 9. A record of personal property and funds which the resident has entrusted to the residence; 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;	S 335		

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11. Any other health-related emergency, or pertinent information which the resident requests the residence to keep on record;

12. A copy of the initial and periodic assessments described in § 2.4.16 of this Part;

13. A copy of the service plan and nurse review as described in § 2.4.16 of this Part;

14. A copy of the residency agreement as described in § 2.4.14(C) of this Part.

This Requirement is not met as evidenced by:
Based on record review and staff interview, it has been determined the residence failed to include, at a minimum, information about any specific health problems of the resident, which may be useful in a medical emergency, including diagnostic and/or therapeutic orders, for the singular resident reviewed receiving outpatient services for occupational therapy, Resident ID #3.

Findings are as follows:

Record review revealed the resident moved into the residence in July of 2025 with a diagnosis including, but not limited to, history of transient ischemic attack (a temporary blockage of a blood vessel in the brain, this blockage deprives a part of the brain of oxygen).

During a surveyor interview with the Director of Wellness (DOW) on 1/15/2026 at 9:41 AM, she revealed this resident has occupational therapy from an outside agency.

Record review failed to reveal outside agency

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S 335	Continued From page 10 service notes indicating any information about any specific health problems of the resident, including any diagnostic information. During a surveyor interview with the DOW in the presence of the Administrator, on 1/16/2026 at approximately 3:15 PM, she could not provide evidence of outside agency service notes for this resident.	S 335	S335 The outside occupat. malthe rapy agency providing services to Resident #3 was contacted immediately. All current and past occupational therapy notes were obtained and placed in residents Medical record Residents care plan has been updated to reflect services from outside agency. Binder made for all residents on any agency services.	
S 400	Residency Requirements 2.4.17.F Resident Assessments/Service Plans 2.4.17 (F) Nurse Review 1. Nurse review is necessary for all levels of licensure. a. A registered nurse shall visit the residence at least once every thirty (30) days except as provided in § 2.4.16(F)(1)(b) of this Part and shall complete a review to include the following: (1) Monitor the medication regimen for all residents; (2) Review any new physician orders and evaluate the health status of all residents by identifying symptoms of illness and/or changes in mental/physical health status; (3) Evaluate the appropriateness of placement for each resident; (4) Make any necessary recommendations to the administrator; (5) Follow up on previous recommendations;	S 400		

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S 400	Continued From page 11 (6) Provide a signed, written report in the residence documenting: (AA) Date and time of assessment; (BB) Recommendations for follow-up; (CC) Progress on previous recommendations; (DD) Verification that the medication listed by the pharmacist on the mediset, blister pack or medication container is current with physician orders (M-1 level only); (EE) Physical assessment identifying symptoms of illness and/or changes in mental or physical health status and appropriateness of placement; (FF) Such reports shall be on file at the residence. (7) Complete the quarterly evaluation of the residence ' s registered medication aide(s) administration of medication. (Approved Department form is available for downloading online). b. In those residences that have one (1) or more licensed registered nurses (i.e., at least one (1) full-time equivalent equal to thirty-five (35) hours) on-site, the nurse review shall be completed at least once every ninety (90) days. This Requirement is not met as evidenced by:	S 400		

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S 400	Continued From page 12 Based on record review and staff interview, it has been determined that the residence failed to ensure that nurse reviews held the required components for 6 of 6 sample residents, Resident ID #s 1, 2, 3, 4, 5, and 6. Findings are as follows: A) Record review revealed the following "Nurse Review(s)" did not contain the time the assessment was completed or address the appropriateness of placement for the following: 1. Record review revealed Resident ID #1 moved into the residence in November of 2024. A "Nurse Review" was completed on 11/27/2024, 12/12/2024, 1/29/2025, 6/9/2025, 9/8/2025, and 12/29/2025. Additionally, the record failed to reveal a "Nurse Review" for April of 2025. 2. Record review revealed Resident ID #2 moved into the residence in July of 2025. A "Nurse Review" was completed on 9/8/2025 and on 12/29/2025. 3. Record review revealed Resident ID #3 moved into the residence in July of 2025. A "Nurse Review" was completed on 9/8/2025 and on 12/29/2025. 4. Record review revealed Resident ID #4 moved into the residence in May of 2017. A "Nurse Review" was completed on 9/11/2024, 10/5/2024, 11/12/2024, 12/12/2024, 1/20/2025, 6/9/2025, 9/8/2025, and on 12/29/2025. 5. Record review revealed Resident ID #5 moved into the residence in March of 2024. A "Nurse Review" was completed on 4/10/2024, 5/10/2024, 6/10/2024, 7/10/2024, 8/10/2024, 9/11/2024,	S 400		

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S 400	Continued From page 13 10/5/2024, 11/12/2024, 6/2/2025, 9/8/2025, and 12/29/2025. Additionally, the record failed to reveal a "Nurse Review" for December of 2024 and April of 2025. 6. Record review revealed Resident ID #6 moved into the residence in November of 2019. A "Nurse Review" was completed on 4/10/2024, 5/10/2024, 6/10/2024, 7/10/2024, 8/10/2024, 9/11/2024, 10/5/2024, 11/12/2024, 12/12/2024, 1/21/2025, 6/9/2025, and 9/8/2025. Additionally, the record failed to reveal a "Nurse Review" for December of 2025. B) Continued non-compliance was identified relative to record review revealing the "Nurse Reviews" did not contain a physical assessment for the following residents on the following dates: 1. Resident ID #1 on 11/27/2024, 12/12/2024, 1/29/2025, and on 12/29/2025. 2. Resident ID #2 on 12/29/2025. 3. Resident ID #3 on 12/29/2025. 4. Resident ID #4 on 9/11/2024, 10/5/2024, 11/12/2024, 12/12/2024, 1/20/2025, and on 12/29/2025. 5. Resident ID #5 on 4/10/2024, 9/11/2024, 10/5/2024, 11/12/2024, and on 12/29/2025. 6. Resident ID #6 on 9/11/2024, 10/5/2024, 11/12/2024, 12/12/2024, and on 1/21/2025. During a surveyor interview with the Director of Wellness, in the presence of the Administrator on 1/16/2026 at approximately 3:30 PM, she was unable to provide evidence that the "Nurse Review(s)" were completed with all required components for the above-mentioned residents. Additionally, she could not provide evidence of Resident ID #1's April 2025 nurse review, Resident ID #5's December 2024 and April 2025	S 400	S400 A monthly nurse review tracking log has been implemented to ensure, reviews are completed timely and no months are missed. Administrator will conduct monthly Audits of nurse reviews to ensure, they are completed for all residents and appropriate evaluation is documented .	

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S 400	Continued From page 14 nurse reviews, and Resident ID #6's December 2025 nurse review.	S 400		
S 405	Residency Requirements 2.4.17.G.1. Resident Assessment/Service Plans 2.4.17 (G) (1) Service Plans 1. Within a reasonable time after move-in, not to exceed seven (7) days, the Administrator shall be responsible for the development of a written service plan based on the initial assessment. The service plan shall include at least: a. The services and interventions needed, including all services provided by outside healthcare agencies (e.g., home nursing care, hospice); b. Description, frequency, duration relating to the service or intervention, including personal assistance, medication, special diets, recreational activities, and other similar services rendered; c. Party responsible for arranging and/or providing the service; and d. The resident ' s requested and/or therapeutically needed recreational and social activities. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to accurately reflect the services and interventions needed on the service plan for two of two residents reviewed for smoking, Resident ID #s 1	S 405		

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S 405	Continued From page 15 and 2. Findings are as follows: Review of a policy titled, "...1.1 Smoking...1. The smoking areas on the grounds of the Residence include the parking lot only..." During a surveyor interview with the Director of Wellness (DOW) on 1/15/2026 at approximately 9:00 AM, she revealed Resident ID #1 and 2 are smokers. 1) Record review revealed Resident ID #1 moved into the residence in November of 2024 with a diagnosis including, but not limited to, chronic obstructive pulmonary disease. During a surveyor observation on 1/16/2026 at 7:30 AM, this resident was observed outside smoking in the back on a bench near the gazebo. After the observation, this surveyor had Certified Medication Technician, Staff C, observe this resident smoking in the back where s/he is not allowed to smoke, according to the facility's policy. Record review of the resident's service plan, dated 11/28/2024, failed to be updated annually, also failed to reveal smoking interventions to keep the resident and other residents safe. 2) Record review revealed Resident ID #2 moved into the residence in July of 2025 with a diagnosis including, but not limited to, Type 2 diabetes mellitus. Record review of the resident's service plan, dated 7/18/2025, failed to reveal smoking interventions to keep the resident and other	S 405		

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S 560	Continued From page 17 be: (A) Stored so they do not contaminate FOOD, EQUIPMENT, UTENSILS, LINENS..." Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 4-601.11 (C) states in part,"...non-contact surfaces of equipment shall be free of an accumulation of dust...other debris..." Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 3-304.12 states in part, "...In-Use Utensils, Between-Use Storage. During pauses in FOOD preparation or dispensing, FOOD preparation and dispensing UTENSILS shall be stored: (A) Except as specified under (B) of this section, in the FOOD with their handles above the top of the FOOD and the container: (B) In FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD with their handles above the top of the FOOD within containers or EQUIPMENT that can be closed, such as bins of sugar, flour, or cinnamon..." Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 3-205.15 Package Integrity, states in part, "FOOD packages shall be in good condition and protect the integrity of the contents so that the FOOD is not exposed to ADULTERATION or potential contaminants." A. During a surveyor observation of the main kitchen on 1/15/2026 at 7:45 AM the following was revealed: -a jug of steaming hot coffee was put into the reach-in refrigerator. -two brooms and a dustpan stored in between the	S 560	All cleaning products have been moved to a designated utility closet away from prep stations and dish areas. Scoops for bins will be stored in seperate holders away from food products Cleaning schedules implemented to keep up with debris build up on carts and kitchen equiptment Condensor Fan in walk-in Cooler has been cleaned from dirt and debris and has been added to maintence tasks going forward	

2/11/26

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S 405	Continued From page 16 residents safe. During a surveyor interview with the DOW on 1/16/2026 at approximately 3:15 PM, in the presence of the Administrator, she could not provide evidence smoking interventions were listed on the above-mentioned service plans, as required. She further could not provide evidence that Resident ID #1's service plan was updated annually, as required, or that the resident followed the facility's smoking policy.	S 405	The service plans for resident #1 and #2 were reviewed and updated immediately Each service plan now includes specific smoking expectations Residents re-educated on smoking protocols	
S 560	Residential Care Services 2.4.23.C Dietetic Services 2.4.23 (C) Dietetic Services C. The food service in each residence shall comply with the appropriate requirements of R.I. Gen. Laws Chapters 21-27 and 21-31, Part 50-10-1 of this Title, Rhode Island Food Code, and such other applicable statutory or regulatory provisions. This Requirement is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to comply with all appropriate standards of the Rhode Island Food Code relative to the main kitchen and the dry storage room. Findings are as follows: Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 6-501.113 Storing Maintenance Tools states in part, "...Maintenance tools such as brooms, mops, vacuum cleaners, and similar items shall	S 560		

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S 560	Continued From page 19 by date of 12/3/2025. -4 cans of chili con carne with beans with a best by date of 8/21/2025. Additionally, one of those cans was dented. During a surveyor interview with the Dietary Supervisor following the above observation, she could not provide evidence that the above-mentioned bottles and cans were within their expiration and use by dates. She further acknowledged the dented can.	S 560	All expired foods have been disgarded and replenished. Food shall follow strict FIFO rules and will be checked by director of food services monthly for expired items. All Kitchenstaff will be in compliance with any certificates needed per guidelines	
S 635	Residential Care Services 2.4.26.A.3.C Medication Services 2.4.26 (A) (3) (C) Medication Services c. For the first three (3) months of employment, a licensed nurse designated by the health care facility, adult day care program, or assisted living residence, as appropriate, shall conduct and document monthly evaluations (in accordance with the evaluation checklist on the Department website) of a medication aide who administers medication. After the first three (3) months, the evaluation shall be conducted no less than quarterly. Copies of said evaluations shall be placed in the medication aides' personnel records. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to have a physician or nurse supervisor conduct and	S 635	2/11/26	

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S 635	Continued From page 20 document evaluations of the Certified Medication Technicians (CMTs) who are administering drugs, and place a copy in the employee's personnel record, for 5 of 5 CMTs reviewed, Staff C, D, E, F, and G. Findings are as follows: 1. Record review revealed Staff C was hired in July of 2022, as a Certified Medication Technician (CMT). Record review failed to reveal evidence that quarterly evaluations were conducted in June and December of 2025. 2. Record review revealed Staff D was hired in August of 2025, as a CMT. Record review failed to reveal evidence that a monthly evaluation was conducted in October of 2025, after the second initial evaluation on 9/10/2025. 3. Record review revealed Staff E was hired in June of 2025, as a CMT. Record review failed to reveal evidence that a monthly evaluation was conducted in August of 2025, after the second initial evaluation on 7/6/2025 or that a quarterly evaluation was conducted in December of 2025. 4. Record review revealed Staff F was hired in January of 2021, as a CMT. Record review failed to reveal evidence that a quarterly evaluation was conducted in June of 2025.	S 635		

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S 635	Continued From page 21 5. Record review revealed Staff G was hired in October of 2019, as a CMT. Record review failed to reveal evidence that quarterly evaluations were conducted in March, June, and December of 2025. During an interview with the Administrator on 1/16/2026 at approximately 11:00 AM, she could not provide evidence that Staff D and Staff E had evaluations the first three months of employment, or that quarterly evaluations were conducted, documented, and placed in the personnel records, as required for Staff C, E, F, and G.	S 635	full review of personnel files for staff C, D, E, F, and G was completed. Administrator will conduct quarterly audits of CMT personnel files to ensure required evaluations are completed timely and documentation is accurate. 2/1/26	
S 640	Residential Care Services 2.4.26.B.1 Medication Services 2.4.26 (B) (1) Administration of Medications 1. Residences licensed at the M1 level may administer medications to residents including, but not limited to, removing medication containers from storage, assisting with the removal of a medication from a container for residents with disability which prevents independence in this act, and/or administering the medication directly to the resident. a. The resident or guardian must provide written authorization for the residence to provide administration of medications. b. Medications shall be administered in accordance with written orders of a physician. The residence must provide in writing, a description of services provided by the residence to each physician, including limitations on service.	S 640		

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S 640	Continued From page 22 c. All medications must be checked against a physician's orders by a licensed nurse, or pharmacist. d. The resident must be identified prior to administration of any medication. e. The medication must be in the original pharmacy-dispensed container with proper label and directions attached and be administered in accordance with such label. f. Injectable medications, including but not limited to insulin, which cannot be self-administered by the resident, must be administered by a licensed nurse. g. There shall be written a policy/procedure for the disposal of hypodermic needles, syringes and other such instruments that is in compliance with Part 20-15-6 of this Title, Hypodermic Needles, Syringes, and Other Such Instruments. (1) The legal destruction of hypodermic needles, syringes or other such instruments is the responsibility of the last entitled or authorized possessor. (AA) All personnel or residents legally authorized to use disposal syringes and needles, shall destroy them after one (1) use. (BB) Excess and undesired needles, syringes and other such instruments shall be stored in impervious, rigid, puncture-resistant container for disposal. Intact needles shall be placed directly into the collection containers. (CC) Personnel handling disposal	S 640		

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S 640	Continued From page 23 waste materials such as needles, syringes, and other such instruments may treat and destroy such waste by a DEM-approved alternative treatment/destruction technology or prepare the regulated medical waste for off-site transport by a DEM-permitted medical waste transporter. h. Individual medication records must be retained for each resident to whom medications are being administered and each dose administered to the resident must be properly recorded. i. Any medication administered by the residence and refused by a resident shall be documented and reported, as appropriate. j. Medications shall be stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access. Provisions for safe storage may include lockable containers, secure spaces, or lockable units, as appropriate to the residence and the resident population. k. All medication in the residence, regardless of whether controlled by employees or by the resident, shall be stored securely as stated in § 2.4.25(A)(3)(a)(8) of this Part. l. All centrally stored medications shall be maintained in accordance with manufacturer ' s labeling and administered by authorized personnel. This Requirement is not met as evidenced by: Based on surveyor observation, record review,	S 640		

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S 640	Continued From page 24 and staff interview, it has been determined that the residence failed to ensure that medications shall be stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access for the singular medication cart reviewed and for Resident ID #s 3, 4, and 5. Findings are as follows: 1) During a surveyor observation of the medication cart on 1/15/2026 at 10:19 AM, the medication cart revealed the following medications without directions for use: - a bottle of Metamucil 4-in-1 Fiber. - a bottle of 4 in 1 daily fiber supplement. - a bottle of vitamin D3 2000 IU (international units). - a bottle of vitamin D3 1000 IU. - a bottle of aspirin low dose. During a surveyor interview, following the above observations with Certified Medication Technician (CMT), Staff F, she acknowledged the above-mentioned medications did not have a label with directions for use on them, as required. 2) Resident ID #3's medication administration record (MAR) indicates the resident is prescribed Lantus insulin. During a surveyor observation of the resident's box of medications an opened Lantus pen, not dated, was revealed. Manufacturer instructions indicate to discard 28 days after opening.	S 640		

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S 640	Continued From page 25 Immediately following the observation, Staff F acknowledged the insulin pen was not dated when opened. 3) Resident ID #4's MAR indicates the resident is prescribed the following medications: - Ondansetron 4 mg (milligrams) tablets. Take one tablet by mouth every 6 hours as needed for nausea. - Meclizine 12.5 mg tablets. Take 1 tablet by mouth three times/day as needed for dizziness. During a surveyor observation of the resident's box of medications failed to reveal the above-mentioned medications. During a surveyor interview with Staff F following the above observations, she acknowledged that the residence did not have the above-mentioned medications for Resident ID #4 to take as needed. 4) Resident ID #5's MAR indicates the resident is prescribed the following medications: - Acetaminophen 325 mg. Take 2 tablets every 6 hours as needed for pain or fever. - Famotidine 20 mg. Take 1 tablet twice/day as needed for gastroesophageal reflux disease. - Lidocaine 4% (percent). Apply 1 patch topically once daily as needed for pain. During a surveyor observation of the resident's box of medications the following medications had labels which stated:	S 640		

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S 640	Continued From page 26 - two bottles of acetaminophen 325 mg. Take 2 tablets three times/day. - a bottle of famotidine 20 mg. Take 2 tablets by mouth every day. - the resident's Lidocaine patch was unavailable. During a surveyor interview with Staff F following the above observations, she acknowledged the physician's order for acetaminophen and famotidine did not match the orders that were on the bottles. She further acknowledged that the residence did not have the resident's Lidocaine patch. During an interview with the Director of Wellness on 1/15/2026 at approximately 11:45 AM, she was unable to provide evidence the above-mentioned medications were stored securely and in such a manner to prevent spoilage, dosage errors, administration errors, and/or inappropriate access, as required.	S 640	All medications observed without directions for use were removed immediately from resident medication storage. properly labeled medications with complete directions were obtained and replaced. The opened Lantus insulin pen was disgarded and replaced which was dated upon opening. Missing PRNs for Resident #4 and 5 were obtained and made avilble All medications labels were reconciled with current physician orders to ensure accuracy Any discreparcies were corrected promptly and documented All CMTs and nursing re-educated on medication labeling, Dating medications, Ensuring medications on MARS are avialble and match physician orders, and proper storage requirements DON will conduct monthly medication audits to ensure medication is in compliance	2/11/26