STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415004	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal of Westerly Nursing Center	79 Beach Street Westerly, RI 02891

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to inform the resident or resident's representative, in advance, of the care to be furnished by the physician or other provider, of the risks and benefits of proposed care or treatment alternatives relative to the ordering of, and administration of, psychotropic medications (a medication that affects brain activities associated with mental processes and behavior) for 5 of 5 residents reviewed for psychotropic consent, Resident ID #s 3, 9, 26, 46 and 64.Findings are as follows:Review of a facility policy titled, Policy and Procedure for Informed Consent for Psychotropic Medications, states in part, .It is the policy of this facility that informed consent for the administration of psychotropic medications will be obtained prior to the administration of any psychotropic medication.Procedure.Facility staff will utilize the Informed Consent Form for Psychotropic Administration provided from the Department of Public Health. Staff will obtain informed consent for any prescribed medication that is used to treat a psychiatric diagnosis or symptoms prior to the administration of the medication.Documentation will include: Name of resident.Date of the discussion.Facility Representative Name and Title.Medication Proposed/Prescribed.Dosage Range for the medication.Purpose of the medication.Risks of use of the medication; if on antipsychotics, the black box warning is reviewed for the use of antipsychotics in dementia-related psychosis.Benefits of use of the medication.Check to consent or refuse the medication.Signature of the resident or representative with date of signature.The side effects need to be written on the sheet or med pass stickers can be used.The completed form will be placed in the medical record.A new consent form will be generated and the above process will be re-addressed in the following circumstances.Each time a renewed prescription of the psychotropic medication falls outside of the dosage range that the resident or representative previously consented to.On an annual bases and with a significant change of status.A) Record review revealed Resident ID #3 was admitted to the facility in December of 2024 with diagnoses including, but not limited to, Alzheimer's disease and anxiety disorder.Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 4 out of 15, indicating severe cognitive impairment.Review of a care plan focus area dated 9/2/2025 revealed the resident is prescribed psychotropic medications related to dementia and behavior management.Record review revealed the resident was prescribed and subsequently administered the following psychotropic medications:-Lorazepam 0.25 milliliters (ml) every 4 hours, as needed-Mirtazapine 15 milligrams (mg) once daily at bedtime-Trazodone 50 mg, twice daily-Haloperidol lactate oral concentrate, 0.5 mg every 8 hours-ABH gel (lorazepam 2mg/ml, diphenhydramine 25 mg/ml, haloperidol 2 mg/ml, gel 2 ml) with instructions to apply topically, twice dailyRecord review failed to reveal evidence that the resident's representative was informed, in advance, of the addition of a new psychotropic medication to the resident's medication regimen or dosage increases to pre-existing psychotropic medications prior to initiating therapy. Additionally, record review failed to reveal evidence that the resident representative was informed of the risks and benefits, side effects, and/or treatment alternatives.Additional record review failed to reveal evidence of a signed psychotropic medication consent form, per facility policy.B) Record review revealed Resident ID #9 was admitted to the facility (continued on next page)

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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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in December of 2024 with diagnoses including, but not limited to, Alzheimer's disease and major depressive disorder, severe with psychotic features.Review of an MDS assessment dated [DATE] revealed a BIMS score of 6 out of 15, indicating severe cognitive impairment.Review of a care plan focus area dated 12/15/2025 revealed the resident is prescribed psychotropic medication related to his/her diagnosis of dementia with psychotic features.Record review revealed the resident was prescribed and subsequently administered the following psychotropic medications:-Trazodone 50 mg, once daily, as needed-Quetiapine fumarate, 12.5 mg once daily-Quetiapine fumarate, 25 mg, once daily in the eveningRecord review failed to reveal evidence that the resident's representative was informed, in advance, of the addition of a new psychotropic medication to the resident's medication regimen or dosage increases to pre-existing psychotropic medications prior to initiating therapy. Additionally, record review failed to reveal evidence that the resident representative was informed of the risks and benefits, side effects, and/or treatment alternatives.Additional record review failed to reveal evidence of a signed psychotropic medication consent form, per facility policy.During a surveyor interview on 2/18/2026 at 8:45 AM, with the resident's representative, s/he revealed that s/he has never been asked to provide consent for Resident ID #9's psychotropic medication use, stating that s/he usually finds out after the fact. S/he further revealed that s/he has never signed a psychotropic medication consent form and never had a conversation with facility staff about the side effects, risks and benefits of the medication or alternative treatment methods. Additionally, s/he revealed that s/he was unaware Resident ID #9 was receiving Trazodone.C) Record review revealed Resident ID #26 was admitted to the facility in September of 2025 with diagnoses including, but not limited to, dementia and depression.Review of an MDS assessment dated [DATE] revealed a BIMS Assessment was unable to be completed, due to the resident being rarely/never understood, indicating severe cognitive impairment.Review of a care plan focus area initiated on 9/8/2025 revealed the resident is prescribed an antidepressant medication due to his/her diagnosis of depression.Record review revealed the resident was prescribed and subsequently administered Effexor XR (a psychotropic medication), 75 mg, with instructions to administer three capsules once daily.Record review revealed the resident was prescribed lorazepam intensol oral concentrate (a psychotropic medication) 2 mg/ml, with instructions to administer 0.5 mg every 6 hours, as needed.Record review failed to reveal evidence that the resident's representative was informed, in advance, of the addition of a new psychotropic medication to the resident's medication regimen or dosage increases to pre-existing psychotropic medications prior to initiating therapy. Additionally, record review failed to reveal evidence that the resident representative was informed of the risks and benefits, side effects, and/or treatment alternatives.Additional record review failed to reveal evidence of a signed psychotropic medication consent form, per facility policy.D) Record review revealed Resident ID #46 was readmitted to the facility in April of 2025 with diagnoses including, but not limited to, depression and anxiety disorder.Review of an MDS assessment dated [DATE] revealed a BIMS score of 13 out of 15, indicating intact cognition.Review of a care plan focus area initiated on 12/5/2023 revealed the resident is prescribed anti-anxiety medication related to his/her diagnosis of anxiety disorder.Review of a care plan focus area initiated on 12/5/2023 revealed the resident is prescribed antidepressant medication related to his/her diagnosis of depression.Record review revealed the resident was prescribed and subsequently administered the following psychotropic medications:-Alprazolam, 0.125 mg, once daily-Buspirone, 10 mg, twice daily-Sertraline, 200 mg, once dailyRecord review failed to reveal evidence that the resident or his/her representative was informed, in advance, of the addition of a new psychotropic medication to the resident's medication regimen or dosage increases to pre-existing psychotropic medications prior to initiating therapy. Additionally, record review failed to reveal evidence that the resident or representative was informed of the risks and benefits, side effects, and/or treatment alternatives.Additional record review failed to reveal evidence of a signed psychotropic medication consent form, per facility policy.During a surveyor interview on 2/18/2026 at 9:59 AM, with Resident ID #46, s/he revealed the facility did not discuss (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	alternative treatments, side effects, nor risk/benefits prior to initiating new psychotropic medications. E) Record review revealed Resident ID #64 was admitted to the facility in June of 2021 with diagnoses including, but not limited to, intellectual disabilities and major depressive disorder.Review of an MDS assessment dated [DATE] revealed a BIMS score of 9 out of 15, indicating moderately impaired cognition.Review of a care plan focus area dated 6/24/2021 revealed the resident is prescribed antidepressant medications related to his/her diagnosis of depression.Review of a care plan focus area dated 11/13/2025 revealed the resident is prescribed anti-anxiety medications related to his/her diagnosis of anxiety disorder.Record review revealed the resident was prescribed and subsequently administered the following psychotropic medications:-Buspirone HCl, 5 mg, three times daily-Duloxetine HCl oral capsule delayed release sprinkle, 60 mg, with instructions to administer 2 capsules, once daily-Trazodone, 25 mg, twice daily, as needed-Trazodone, 50 mg, once daily at bedtime-Trazodone, 75 mg, twice daily-Seroquel 12.5 mg, once daily-Seroquel 12.5 mg, three times a day-Seroquel 25 mg, twice daily-Divalproex sodium, 500 mg, twice dailyAdditional record review revealed the resident was prescribed trazodone 25 mg, every 12 hours as needed.Record review failed to reveal evidence that the resident's representative was informed, in advance, of the addition of a new psychotropic medication to the resident's medication regimen or dosage increases to pre-existing psychotropic medications prior to initiating therapy. Additionally, record review failed to reveal evidence that the resident representative was informed of the risks and benefits, side effects, and/or treatment alternatives.Additional record review failed to reveal evidence of a signed psychotropic medication consent form, per facility policy.During a surveyor interview on 2/19/2026 at 9:44 AM, with Resident ID # 64's resident representative, s/he revealed that s/he has never been asked to provide consent for Resident ID #64's psychotropic medication use, indicating that staff only make him/her aware of the implementation of new psychotropic medications. S/he further revealed that staff has not discussed any side effects, risks or benefits, or any alternative treatment methods prior to initiating psychotropic medication.During a surveyor interview on 2/18/2026 at 8:57 AM, with Licensed Practical Nurse (LPN), Staff A, she revealed that staff speak with resident representatives when a new psychotropic medication is initiated and discuss the reason for the increase and any side effects or potential interactions the medication could have. She revealed that this conversation, including what was discussed, should be documented in a progress note. She further revealed that resident representatives do not sign a consent form for psychotropic medications, stating, it is not our policy.During surveyor interviews on 2/18/2026 at 9:44 AM and at 11:04 AM with Unit Manager, Registered Nurse, Staff B, she revealed that she obtains verbal consent from residents and or representatives and discusses side effects as well as risk/benefits of the medication. She revealed that the discussion should be documented in a progress note and indicated that she keeps the documentation simple, writing that the representative or resident agrees. During a surveyor interview on 2/18/2026 at approximately 10:05 AM, with Nurse Practitioner, Staff C, she revealed that she would expect consent to be obtained from the resident, representative, or family, when initiating a new psychotropic medication. She further revealed that she would expect staff to discuss the side effects and risks/benefits prior to initiating therapy.During a surveyor interview on 2/18/2026 at 1:33 PM, with the Director of Nursing Services, she was unable to provide evidence that Resident ID #s 3, 9, 26, 46, 64 and/or their representatives were informed, in advance, of the addition of a new psychotropic medication to the resident's medication regimen or dosage increases to pre-existing psychotropic medications, prior to initiating therapy. Additionally, she was unable to provide evidence that the resident/representative was informed of the risks and benefits, side effects, and/or treatment alternatives. Furthermore, she was unable to provide evidence of signed consents for psychotropic medications for Resident ID #s 3, 9, 26, 46 and 64, per facility policy.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on clinical record review and staff interview, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 3 of 3 residents reviewed for Hospice services, Resident ID #s 3, 5, and 48 and and for 1 of 1 resident reviewed for a medication with administration parameters, Resident ID #67.Findings are as follows:1. 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 that the orders are in error or would harm the clients.a. Record review revealed Resident ID #3 was admitted to the facility in December of 2024 with a diagnosis including, but not limited to, Alzheimer's disease. Further record review revealed the resident was admitted to hospice services in January of 2026.Record review revealed Resident ID #3 was seen by a hospice nurse on 2/16/2026 and the following recommendations were made:-Amoxicillin Clavulanate 875-125 milligrams (mg), by mouth, twice daily, for five days-Miralax 17 grams mixed in 6-8 ounces of fluids, by mouth, once dailyRecord review revealed a physician's order dated 2/16/2026 at 9:52 PM for Amoxicillin-Pot Clavulanate Oral Tablet 875-125 mg, with instructions to administer 1 tablet by mouth two times a day for respiratory symptoms for 5 Days, was entered into the resident's record by Licensed Practical Nurse (LPN), Staff F. Further review of the physician's order revealed the Amoxicillin-Pot Clavulanate was documented as being ordered by the Medical Director and was obtained over the phone.Record review revealed a physician's order dated 2/16/2026 at 10:00 PM for MiraLAX Oral Powder 17 GM/SCOOP, with instructions to administer 2 scoops by mouth one time a day for constipation, was entered into the resident's record by Staff F. Further review of the physician's order revealed the MiraLAX was documented as being received via a telephone order from the Medical Director.Record review failed to reveal evidence that the provider was notified of the 2/16/2026 hospice recommendations for Resident ID #3, prior to the medications being initiated.Surveyor interviews were attempted with Staff F on 2/19/2026 at 8:52 AM and 10:03 AM. Voice messages were left; however, a return call was not received by the surveyor.During a surveyor interview on 2/19/2026 at 8:56 AM, with Nurse Practitioner (NP), Staff C, she revealed that any medication recommendations received after 6:00 PM, would be addressed with the on-call providers, which should be documented in a progress note. Lastly, she revealed that she did not personally approve the hospice recommendations from 2/16/2026, indicating she was not aware Resident ID #3 was receiving an antibiotic.During a surveyor interview on 2/19/2026 at 9:56 AM, with the Medical Director, he revealed that he did not recall approving Resident ID #3's antibiotic recommendation from hospice on 2/16/2026, indicating it may have been approved by another provider.During a surveyor interview on 2/19/2026 at 10:23 AM, with Unit Manager, Registered Nurse, Staff B, she revealed that on Tuesdays and Fridays, the Medical Director is the covering provider and on Mondays, Wednesdays, Thursdays, Staff C is the covering provider. She revealed the facility has a communication book that is utilized by the providers; however, she revealed that the Medical Director does not always review the communication binder, indicating that staff have to track him down.b. Record review revealed Resident ID #5 was admitted to the facility in June of 2021 with a diagnosis including, but not limited to, chronic pain. Further record review revealed the resident was admitted to hospice services in January of 2026.Record review revealed Resident ID #5 was seen by a hospice nurse on 2/6/2026 and the following recommendations were made:-Oxycodone (pain medication) 5 mg give one tab every six hours scheduled-Oxycodone 5 mg give one tab every six hours as needed for painRecord review revealed a physician's order dated 2/7/2026 at 7:29 AM was entered into the resident's record by LPN, Staff G, for oxycodone 5 mg, with instructions to administer one tablet by mouth every six hours for pain. Further review of the physician's order revealed the oxycodone was documented as being received via a telephone order from the Medical Director.Record review revealed a physician's order dated 2/6/2026 at 8:36 PM was entered into the resident's record by LPN, Staff H, for oxycodone 5 mg, with (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	instructions to administer one tablet by mouth every six hours as needed for pain. Further review of the physician's order for the oxycodone was documented as being received via a telephone order from the Medical Director. Record review failed to reveal evidence that the provider approved or was notified of the 2/6/2026 hospice recommendations for Resident ID #5, prior to the medications being initiated.c. Record review revealed Resident ID #48 was admitted to the facility in August of 2025 with a diagnosis including, but not limited to, dementia. Further review revealed the resident was receiving hospice services.Record review revealed Resident ID #48 was seen by a hospice nurse on 2/13/2026 and the following recommendations were made:-Discontinue the following medications: mirtazapine, aspirin, Vitamin D, Vitamin B, multivitamin, rosuvastatin, and the house nutritional supplement.-Schedule lorazepam 2 mg/milliliter (ml), with instructions to administer 0.5mg/0.25ml, every 6 hours, around the clock.-Add 2-4 liters of oxygen, as needed, for comfort and shortness of breath-Add Bactrim (an antibiotic medication), 200 mg - 40 mg/5ml, with instructions to give 20 ml, twice daily for 7 days.Record review revealed on 2/13/2026, LPN, Staff I, discontinued the following medications:-Mirtazapine 2.5 mg, once daily-Aspirin 81 oral tablet, once daily-Cholecalciferol (Vitamin D) 25 micrograms, once daily-Multivitamin, once daily-Rosuvastatin Calcium 40 mg, once daily-House frozen supplement, 4 ounces, twice dailyRecord review revealed a physician's order initiated on 2/13/2026 at 3:35 PM, for lorazepam 2 mg/ml, with instructions to administer 0.25 ml by mouth every 6 hours, was entered into the resident's record by Staff I. Further review of the physician's order revealed the lorazepam was documented as being received via a verbal order from the Medical Director.Record review revealed a physician's order initiated on 2/13/2026 at 3:37 PM, for Bactrim 200 mg-40 mg/5 ml, with instructions to administer 20 ml by mouth every 12 hours, for 7 Days, was entered into the resident's record by Staff I. Further review of the physician's order revealed the lorazepam was documented as being received via a verbal order from the Medical Director.Record review revealed a progress note dated 2/13/2026 at 3:39 PM, authored by Staff I, which states, .Hospice in to see resident, new [recommendation] [discontinue] mirtazapine, supplements, aspirin, vitamin D, multivitamin, rosuvastatin. Schedule lorazepam 2mg/ml, give 0.5 mg/0.25ml [every 6 hours] around the clock. Add Bactrim 200mg-40ml/5ml, give 20ml [twice daily for] 7 days. APRN [Advanced Practice Registered Nurse] notified and family.During a surveyor interview on 2/19/2026 at 8:56 AM, with NP, Staff C, she revealed that on 2/13/2026, the covering provider was the Medical Director, indicating he would have been the provider to address Resident ID # 48's hospice recommendations.During a surveyor interview on 2/19/2026 at 9:11 AM, with the Medical Director, he revealed that he did not recall approving Resident ID #48's hospice recommendations, indicating they might have been approved by another provider.During surveyor interviews on 2/19/2026 at 10:13 AM and 11:01 AM, with Staff I, she initially stated that she spoke with Staff C to approve Resident ID #48's hospice recommendations. However, when the surveyor revealed that she had already spoke to Staff C who had stated that she was not the provider who was on call for the approval for the resident's new hospice recommendations, Staff I revealed that she had not spoken to any provider prior to implementing the hospice recommendations for Resident ID #48. She further revealed that the process for any hospice recommendations is that hospice will give the facility nurses their recommendations, facility nurses will implement the recommendations, sign the paper copy provided from the hospice nurse, and place the paper into a communication binder for a provider to review when they come into the facility.During a surveyor interview on 2/19/2026 at 11:06 AM, with Staff C, she revealed that she would expect nursing to reach out to the providers and discuss any hospice recommendations prior to initiating or discontinuing orders.During a surveyor interview on 2/19/2026 at 11:36 AM, with the Medical Director, he revealed that he has not spoken to any staff regarding the hospice recommendations for Resident ID #s 3, 5, and 48. He revealed that nurses do not always call the providers for approval of hospice recommendations, indicating he did not expect them too. However, he revealed that he would expect nursing to speak with him regarding the initiation of an antibiotic medication for a hospice resident.During a surveyor interview on 2/19/2026 at 12:14 PM, (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with the Director of Nursing Services, she was unable to provide evidence that the above Hospice recommendations for Resident ID #s 3, 5, and 48 were approved by a provider, prior to initiating or discontinuing medications.2. Record review revealed Resident ID #67 was admitted to the facility in October of 2025 with a diagnosis including, but not limited to, essential hypertension (high blood pressure).Review of a physician's order dated 11/21/2025 revealed to administer metoprolol succinate (a medication prescribed to lower blood pressure) extended release administer 12.5 milligrams once daily at 8:00 AM. Additionally, the medication was to be held if the resident's systolic blood pressure (the top number in a reading, measuring the maximum pressure in your arteries when the heart contracts and pumps blood) was below 110.Further review of the above order failed to have an associated task to ensure a blood pressure reading is obtained prior to administering the medication.Record review revealed the resident's blood pressure on the following dates and times:-11/22/2025: 93/60 at 1:47 PM-11/23/2025: 98/56 at 2:08 PMRecord review failed to reveal evidence that the resident's blood pressure was obtained prior to administering the resident his/her medication.Review of the November 2025 Medication Administration Record revealed the resident was administered his/her metoprolol succinate for 2 of 2 opportunities when the medication should have been held, as ordered.During a surveyor interview on 2/17/2026 at approximately 10:15 AM with Unit Manager, RN, Staff B, she acknowledged the resident's blood pressures on the above-mentioned dates and revealed that the medication should have been held, as ordered.During a surveyor interview on 2/17/2026 at approximately 12:50 PM with the DNS, she was unable to provide evidence that the physician's order for metoprolol was held per the parameter that was ordered by the provider.Cross reference F 710

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on clinical record review and staff interview, the facility failed to provide appropriate treatment and services for 1 of 3 residents reviewed with a foley catheter (a flexible plastic tube inserted into your bladder to drain urine), Resident ID #70, and for 1 of 1 resident reviewed with a suprapubic catheter (SP tube, a flexible plastic tube inserted into your bladder to drain urine through an opening in the abdomen), Resident ID #5.Findings are as follows:1. Record review revealed that Resident ID #5 was admitted to the facility in June of 2021 with a diagnosis including, but not limited to, obstructive and reflux uropathy (a condition when urine flow is blocked or flows backward into the kidneys).Record review revealed that the resident has an SP tube.Review of a urology continuity of care form document dated 11/6/2024 revealed that the facility requested to complete catheter exchanges in the facility and decrease the frequency of catheter exchanges which were being completed monthly at the urology appointments. Additionally, it indicated that the urologist provided approval for the catheter exchanges to be completed at five-week intervals in the facility.Record review failed to reveal an order was in place for routine catheter exchanges at five-week intervals as approved by the resident's urologist.During a surveyor interview on 2/18/2026 at 9:37 AM with Unit Manager, Registered Nurse, Staff B, she revealed that the resident is no longer followed by the urologist, due to the resident frequently cancelling his/her appointments and the only reason she was going was to have his/her SP tube exchanged. Staff B further revealed that the resident's SP tube should be exchanged approximately every four weeks. Additionally, she acknowledged that there was no order in place to exchange the SP tube and was unsure of the last time it was exchanged.During a surveyor interview on 2/18/2026 at 10:05 AM with the Nurse Practitioner, Staff C, she revealed that she would expect exchanges to be completed at least every 28 days and an order to be in place for Resident ID #5's SP tube.2. Record review revealed that Resident ID #70 was admitted to the facility in January of 2026 with a diagnosis including, but not limited to, retention of urine.Record review revealed Resident ID #70 has an indwelling foley catheter in place.Record review failed to reveal evidence of a physician's order for the foley catheter to include: an appropriate diagnosis for the indication for catheter use, the catheter type and size, and the catheter's balloon size (an inflatable portion of the catheter near the catheter's tip that is inflated to secure the catheter's placement).During a surveyor interview on 2/17/2026 at 11:19 AM with Licensed Practical Nurse, Staff I, she acknowledged that the resident has an indwelling foley catheter and should have orders in place.During a surveyor interview on 2/18/2026 at 1:24 PM with the Director of Nursing Services (DNS), she was unable to provide evidence that the facility provided appropriate treatment and services relative to Resident ID #s 5's SP tube and Resident ID #70s indwelling catheter.Additional, record review revealed a provider's order dated 2/17/2026 for Resident ID #70's foley catheter that included the catheter and balloon size was entered into his/her medical record after it was brought to the facility's attention by the surveyor.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. Based on clinical record review and staff interview, the facility failed to ensure the medical care of each resident is supervised by a physician for 3 of 3 resident's reviewed who receive Hospice services, Resident ID #s 3, 9 and 48.Findings are as follows:1. 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 that the orders are in error or would harm the clients.a. Record review revealed Resident ID #3 was admitted to the facility in December of 2024 with a diagnosis including, but not limited to, Alzheimer's disease. Further record review revealed the resident was admitted to hospice services in January of 2026.Record review revealed Resident ID #3 was seen by a hospice nurse on 2/16/2026 and the following recommendations were made:-Start Amoxicillin Clavulanate 875-125 milligrams (mg), by mouth, twice daily, for five days-Start Miralax 17 grams mixed in 6-8 ounces of fluids, by mouth, once dailyRecord review revealed a physician's order dated 2/16/2026 at 9:52 PM for Amoxicillin-Pot Clavulanate Oral Tablet 875-125 mg, with instructions to administer 1 tablet by mouth two times a day for respiratory symptoms for 5 Days, was entered into the resident's record by Licensed Practical Nurse (LPN), Staff F. Further review of the physician's order revealed the Amoxicillin-Pot Clavulanate was documented as being ordered by the Medical Director and was obtained over the phone.Record review revealed a physician's order dated 2/16/2026 at 10:00 PM for MiraLAX Oral Powder 17 GM/SCOOP, with instructions to administer 2 scoops by mouth one time a day for constipation, was entered into the resident's record by Staff F. Further review of the physician's order revealed the MiraLAX was documented as being received via a telephone order from the Medical Director.Record review failed to reveal evidence that the provider was notified of the 2/16/2026 of the hospice recommendations for Resident ID #3, prior to the medications being initiated by Staff F. Additional record review revealed that, as of 2/19/2026, Resident ID #3's physician's orders for MiraLAX and Amoxicillin-Pot Clavulanate were not signed by a provider.During a surveyor interview on 2/19/2026 at 8:56 AM, with Nurse Practitioner, Staff C, she revealed that any medication recommendations received after 6:00 PM, would be addressed with the on-call providers, which should be documented in a progress note. She revealed that she did not personally approve the hospice recommendations from 2/16/2026, indicating she was not aware Resident ID #3 was receiving an antibiotic.During a surveyor interview on 2/19/2026 at 9:56 AM, with the Medical Director, he revealed that he did not recall approving Resident ID #3's antibiotic recommendation from hospice on 2/16/2026, indicating it may have been approved by another provider.b. Record review revealed Resident ID #5 was admitted to the facility in June of 2021 with a diagnosis including, but not limited to, chronic pain. Further record review revealed the resident was admitted to hospice services in January of 2026.Record review revealed Resident ID #5 was seen by a hospice nurse on 2/6/2026 and the following recommendations were made:-Oxycodone (pain medication) 5 mg give one tab every six hours scheduled-Oxycodone 5 mg give one tab every six hours as needed for painRecord review revealed a physician's order dated 2/7/2026 at 7:29 AM for oxycodone 5 mg, with instructions to administer one tablet by mouth every six hours for pain, was entered into the resident's record by LPN, Staff G. Further review of the physician's order revealed the oxycodone was documented as being ordered by the Medical Director and was obtained over the phone.Record review revealed a physician's order dated 2/6/2026 at 8:36 PM for oxycodone 5 mg, with instructions to administer one tablet by mouth every six hours as needed for pain, was entered into the resident's record by LPN, Staff H. Further review of the physician's order revealed the oxycodone was documented as being received via a telephone order from the Medical Director.Record review failed to reveal evidence that a provider was notified of the 2/6/2026 hospice recommendations for Resident ID #5, prior to the medications being initiated by Staff G and H. c. Record review revealed Resident ID #48 was admitted to the facility in August of 2025 with a diagnosis including, but not limited to, dementia. Further review revealed the resident is (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	receiving Hospice services. Record review revealed Resident ID #48 was seen by a hospice nurse on 2/13/2026 and the following recommendations were made:-Discontinue the following medications: mirtazapine, aspirin, Vitamin D, Vitamin B, multivitamin, rosuvastatin, and the house nutritional supplement.-Schedule lorazepam 2 mg/milliliter (ml), with instructions to administer 0.5mg/0.25ml, every 6 hours, around the clock.-Add 2-4 liters of oxygen, as needed, for comfort and shortness of breath-Add Bactrim (an antibiotic medication), 200 mg - 40 mg/5ml, with instructions to give 20 ml, twice daily for 7 days.Record review revealed on 2/13/2026, Staff I, discontinued the following medications:-Mirtazapine 2.5 mg, once daily-Aspirin 81 oral tablet, once daily-Cholecalciferol (Vitamin D) 25 micrograms, once daily-Multivitamin, once daily-Rosuvastatin Calcium 40 mg, once daily-House frozen supplement, 4 ounces, twice dailyRecord review revealed a physician's order initiated on 2/13/2026 at 3:35 PM, for lorazepam 2 mg/ml, with instructions to administer 0.25 ml by mouth every 6 hours, was entered into the resident's record by Staff I. Further review of the physician's order revealed the lorazepam was documented as being ordered by the Medical Director and was obtained verbally. Additionally, this order was signed off by the Medical Director on 2/16/2026.Record review revealed a physician's order initiated on 2/13/2026 at 3:37 PM, for Bactrim 200 mg-40 mg/5 ml, with instructions to administer 20 ml by mouth every 12 hours, for 7 Days, was entered into the resident's record by Staff I. Further review of the physician's order revealed the lorazepam was documented as being ordered by the Medical Director and was obtained verbally. Additionally, this order was signed off by the Medical Director on 2/16/2026.Record review revealed a progress note dated 2/13/2026 at 3:39 PM, which state, .Hospice in to see resident, new [recommendation] [discontinue] mirtazapine, supplements, aspirin, vitamin D, multivitamin, rosuvastatin. Schedule lorazepam 2mg/ml, give 0.5 mg/0.25ml [every 6 hours] around the clock. Add Bactrim 200mg-40ml/5ml, give 20ml [twice daily for] 7 days. APRN [Advanced Practice Registered Nurse] notified and family.During surveyor interviews on 2/19/2026 at 10:13 AM and 11:01 AM, with Staff I, she initially stated that she spoke with Staff C to approve Resident ID #48's hospice recommendations. However, when the surveyor revealed that she had already spoken to Staff C, who had stated that she was not the provider who was on call for the approval for the resident's new hospice recommendations, Staff I revealed that she had not spoken to any provider prior to implementing the hospice recommendations for Resident ID #48. She further revealed that the process for any hospice recommendations is that hospice will give the facility nurses their recommendations, facility nurses will implement the recommendations, sign the paper copy provided from the hospice nurse, and place the paper into a communication binder for a provider to review when they come into the facility.During a surveyor interview on 2/19/2026 at 10:23 AM, with Unit Manager, Registered Nurse, Staff B, she revealed that on Tuesdays and Fridays, the Medical Director is the covering provider and on Mondays, Wednesdays, Thursdays, Staff C is the covering provider. She revealed the facility has a communication book that is utilized by the providers; however, she revealed that the Medical Director does not always review the communication binder, indicating that staff have to track him down.During surveyor interviews on 2/19/2026 at 8:56 AM and 11:06 AM, with Staff C, she revealed that on Friday, 2/13/2026, the covering provider was the Medical Director, indicating he would have been the provider to address Resident ID #48's hospice recommendations. She revealed that when she goes into the electronic medical record to sign physician's orders, she approves orders in a batch, indicating that each order is not individually reviewed by her.During surveyor interviews on 2/19/2026 at 9:11 AM and 11:36 AM, with the Medical Director, he revealed that he did recall approving Resident ID #48's hospice recommendations from 2/13/2026, indicating they might have been approved by another provider, although he signed off the order on 2/16/2026. When asked by the surveyor if he recalls signing Resident ID #48's orders on 2/16/2026, he acknowledged that he signed off the orders, indicating that he did so assuming that another provider had approved them.During a surveyor interview on 2/19/2026 at 12:14 PM, with the Director of Nursing Services, she revealed that the facility has been advised by the Medical Director that he only wants to be aware if there is a change in condition or an (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	emergency situation, indicating they have been told to put the orders directly into the system, if it comes from a specialty provider, such as hospice, without consulting the Medical Director first. Further, she was unable to provide evidence that the medical care of each Hospice resident is supervised by a physician.Cross reference F658

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on clinical record review and staff interview, the facility failed to ensure that the resident's drug regimen is free from unnecessary drugs for 2 of 2 residents reviewed for antibiotic use who were receiving hospice services, Resident ID #s 3 and 48. Findings are as follows:Review of a facility policy titled, Antibiotic Stewardship Program Policy dated January 2025 states in part, .The facility uses the CDC's NHSN [Centers for Disease Control and Prevention's National Healthcare Safety Network] Surveillance Definitions, Updated McGeer criteria, Loeb Minimum Criteria or other surveillance tool to define infections.Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness.1. Review of the CDC/NHSN Surveillance Definitions for Specific Types of Infections dated January 2026 states in part, LOWER RESPIRATORY INFECTION, OTHER THAN PNEUMONIA LUNG-Other infection of the lower respiratory tract and pleural cavity .Other infections of the lower respiratory tract must meet at least one of the following criteria:1. Patient has organism(s) seen on Gram stain of lung tissue or pleural fluid or identified from lung tissue or pleural fluid* (when pleural fluid was obtained during thoracentesis or within 24 hours of chest tube placement) by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment, for example, not Active Surveillance Culture/Testing (ASC/AST). 2. Patient has a lung abscess or other evidence of infection (for example, empyema) on gross anatomic or histopathologic exam. 3. Patient has imaging test evidence of abscess or infection (excludes imaging test evidence of pneumonia) which if equivocal is supported by clinical correlation, specifically, physician or physician designee documentation of antimicrobial treatment for lung infection).Record review revealed that Resident ID #3 was admitted to the facility in December of 2024 with diagnoses including, but not limited to, Alzheimer's and dementia.Record review revealed that Resident ID #3 was admitted to hospice services in January of 2026.Record review of a Multi-Discipline Note dated 2/16/2026 states in part, Routine RN [Registered Nurse] visit.Hospice Rec [Recommendation]: Amoxicillin Clavulanate [antibiotic] 875-125 mg [milligram].5 days.Record review revealed a physician's order dated 2/16/2026 for Amoxicillin Clavulanate 875-125 mg, twice daily for 5 days.Record review failed to reveal evidence of signs and symptoms indicating the resident had a respiratory infection per the NHSN surveillance definition.Further record review failed to reveal evidence that the hospice recommendations were reviewed for appropriateness with the provider per the facility policy.During a surveyor interview on 2/19/2026 at 8:56 AM with Nurse Practitioner (NP), Staff C, she revealed that she was unaware of Resident ID #3 being started on an antibiotic.During a surveyor interview on 2/19/2026 at 9:56 AM with the Medical Director, he revealed that he was unaware of Resident ID #3 being started on an antibiotic. Additionally, he was unable to provide evidence that a review of the antibiotic's appropriateness was conducted.2.Review of the CDC/NHSN Surveillance Definitions for Specific Types of Infections dated January 2026 states in part, Urinary system infections must meet at least one of the following criteria: 1. Patient has organism(s) identified from fluid (not urine) or tissue from affected site by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment, for example, not Active Surveillance Culture/Testing (ASC/AST) 2. Patient has an abscess or other evidence of infection on gross anatomical exam, during invasive procedure, or on histopathologic exam. 3. Patient has one of the following signs or symptoms: fever (>38.0 C) localized pain or tenderness* And at least one of the following: a. purulent drainage from affected site b. organism(s) identified from blood by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment, for example, not Active Surveillance Culture/Testing (ASC/AST). AND imaging test evidence definitive for infection, for example, ultrasound, CT scan, magnetic resonance imaging [MRI], or radiolabel scan [gallium, technetium]), which if equivocal is supported by clinical correlation, specifically, physician or physician designee documentation of antimicrobial treatment for urinary system infection.Record (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review revealed that Resident ID #48 was admitted to the facility in August of 2025 with a diagnosis including, but not limited to, stroke.Review of a document titled, Visit Notes-Hospice dated 2/13/2026 revealed that Resident ID #48 presented with increased confusion, unresponsiveness and his/her spouse was questioning a urinary tract infection. Additional review revealed that hospice recommended to start Bactrim (antibiotic) 800 mg twice daily for 7 days.Record review revealed lab results dated 2/11/2026, 2 days prior to the start of the antibiotic, with a white blood cell count (WBC) of 7.3 (regular WBC is 4 -10), which is not indicative of an infection.Record review revealed a physician's order dated 2/13/2026 for Bactrim 800mg every 12 hours for 7 days.Record review failed to reveal evidence of signs and symptoms indicating a urinary tract infection per the NHSN surveillance definition.Further record review failed to reveal evidence that the hospice recommendations were reviewed for appropriateness with the provider per the facility policy.During a surveyor interview on 2/19/2026 at 8:56 AM with Staff C, she revealed that she was unaware of Resident ID #48 was started on an antibiotic.During a surveyor interview on 2/19/2026 at 9:56 AM with the Medical Director, he revealed that he was unaware of Resident ID #48 being started on an antibiotic. Additionally, he was unable to provide evidence that a review of the antibiotic's appropriateness was conducted.During a surveyor interview on 2/19/2026 at 12:14 PM with the Director of Nursing Services she was unable to provide evidence that Resident ID #s 3 and 48 had symptoms of infection. Additionally, she was unable to provide evidence that Resident ID #s 3 and 48 were kept free of unnecessary medications. Cross Reference F710 and F881

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on clinical record review, surveyor observation, and staff interview, the facility failed to store and label drugs and biologicals in accordance with currently accepted professional standards for 3 of 3 medication carts observed and 1 of 1 medication rooms observed.Findings are as follows:Review of an undated facility policy titled, Storage of Medications states in part, The facility stores all drugs and biologicals in a safe, secure, and orderly manner.1a. During a surveyor observation on 2/16/2026 at 10:01 AM of the Westerly Unit Medication Cart, in the presence of Licensed Practical Nurse (LPN), Staff A, revealed the following:-One bottle of Nutricia UTI-Stat 30 fluid ounces open and undated. Review of the manufacturer's instructions on the bottle states, Discard 3 months after opening.-One bottle of Nutricia Pro-Stat Concentrate liquid protein medical food, open and undated.Review of the manufacturer's instructions on the bottle states, Discard 3 months after opening.-One bottle of Lorazepam Oral Concentrate 2 milligram (mg)/ milliliter (ml) for Resident ID #3, open and undated and inside the medication cart.Review of the manufacturer's instructions on the box revealed to discard 90 days after opening and to keep refrigerated.During a surveyor interview immediately following the above observation with Staff A, she acknowledged that the above noted medications were opened, undated and that the Lorazepam Oral Concentrate should be refrigerated.1b. During a surveyor observation on 2/16/2026 at 10:18 AM of the Watch Hill Unit Medication Cart, in the presence of Registered Nurse (RN), Staff L, revealed the following:-One Trelegy Ellipta inhaler dated 10/31/2025 for Resident ID #5.Review of the manufacturer's instructions on the box indicate to discard 6 weeks after opening.-One bottle of Lorazepam Oral Concentrate 2mg/ml for Resident ID #14 open and stored in the medication cart.Review of the manufacturer's instructions on the box revealed to keep refrigerated.During a surveyor interview directly following the above observation with Staff L she acknowledged that the Trelegy inhaler was expired and the Lorazepam Oral Concentrate was not stored properly in the refrigerator.1c. During a surveyor observation on 2/16/2026 at 10:30 AM of the Mystic Unit Medication Cart in the Presence of RN, Staff K, revealed the following:-One bottle of UTI-Stat urinary tract protection complex 30 fluid ounces, open and not dated.Review of the manufacturer's instructions on the bottle revealed to discard 3 months after opening.-One vial of Humalog 100 units/ml insulin for Resident ID #30 with an open date of 1/15/2026 and expiration date of 2/12/2026.-Two Wixela Inhalers for Resident ID #11, open and undated.Review of the manufacturer's instructions on the box reveal to discard 1 month after opening.-One Trelegy Ellipta for Resident ID #12, open and undated.Review of the manufacturer's instructions on the box reveal to discard 6 weeks after opening.-One Wixela Inhaler for Resident ID #22, open and undated.Review of the manufacturer's instructions on the box revealed to discard 1 month after opening.During a surveyor interview immediately following the above observation with Staff K she acknowledged the insulin is expired and the inhalers were opened and undated.2. During a surveyor observation on 2/16/2026 at 10:25 AM on the Medication Room in the presence of RN, Staff L, revealed 1 vial of tuberculin purified protein derivative solution (PPD solution), opened and undated.Review of the manufacturer's instructions on the box revealed to discard 30 days after opening.During a surveyor interview with Staff L she acknowledged that the PPD solution was open and undated.During a surveyor interview on 2/17/2026 at 10:58 AM with the Director of Nursing Services she revealed that she would expect staff to date medication when it is opened and to be aware of when medications should be discarded.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on clinical record review and staff interview, the facility failed to establish an Infection Prevention and Control Program (IPCP) that must include, at a minimum, an antibiotic stewardship program which includes antibiotic use protocols and a system to monitor antibiotic use to ensure that residents who require an antibiotic, are prescribed the appropriate antibiotic for 3 of 3 residents reviewed for antibiotic use, Resident ID #s 1, 3, and 48. Findings are as follows:According to the Centers for Disease Control and Prevention (CDC) document titled, The Core Elements of Antibiotic Stewardship for Nursing Homes states in part, Perform antibiotic 'time outs.' .Nursing homes should have a process in place for a review of antibiotics by the clinical team two to three days after antibiotics are initiated to answer these key questions: Does this resident have a bacterial infection that will respond to antibiotics?If so, is the resident on the most appropriate antibiotic(s), dose, and route of administration?Can the spectrum of the antibiotic be narrowed or the duration of therapy shortened (i.e., de-escalation)?Would the resident benefit from additional infectious disease/antibiotic expertise to ensure optimal treatment of the suspected or confirmed infection . A. Record review revealed that Resident ID #1 was readmitted to the facility in April of 2025 with diagnoses including, but not limited to, pneumonia and respiratory failure.Record review revealed a physician's order dated 2/17/2026 for Cefdinir (an antibiotic) oral 300 milligrams (mg) twice a day for 7 days for pneumonia.Record review failed to reveal evidence of an antibiotic review or an antibiotic time out.B. Record review revealed that Resident ID #3 was admitted to the facility in December of 2024 with diagnoses including, but not limited to, Alzheimer's and dementia.Record review revealed a physician's order dated 2/16/2026 for Amoxicillin Clavulanate (an antibiotic) 875-125 mg, twice daily for 5 days.Record review failed to reveal evidence of an antibiotic review or an antibiotic time out.C. Record review revealed that Resident ID #48 was admitted to the facility in August of 2025 with a diagnosis including, but not limited to, stroke.Record review revealed a physician's order dated 2/13/2026 for Bactrim (an antibiotic) 800mg every 12 hours for 7 days.Record review failed to reveal evidence of an antibiotic review or an antibiotic time out.During a surveyor interview on 2/18/2026 at 12:10 PM with the Director of Nursing Services she revealed that they do not perform antibiotic time outs or reviews 48-72 hours after initiating an antibiotic, as required by the CDC. Cross Reference F710 and F757

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on surveyor observation, clinical record review, and staff interview, the facility failed to provide appropriate treatment and services for 1 of 1 resident reviewed who had skin impairments without any treatment orders in place. Additionally, the facility failed to ensure the resident was placed on Enhanced Barrier Precautions (EBP, in addition to standard precautions, EBP includes wearing personal protective equipment (PPE) that includes a gown and gloves when performing high contact care activities) as required relative to his/her wounds, Resident ID #14.Findings are as follows:1. Record review revealed the resident was admitted to the facility in December of 2023 with a diagnosis including, but not limited to, stroke.1a. Review of a policy titled, Wound Treatment Management last revised in January of 2026 states in part, Wound treatments will be provided in accordance with physician orders.In the absence of treatment orders, the licensed nurse will notify the physician to obtain treatment orders.During a surveyor observation in the presence of Hospice Nursing Assistant, Staff J, on 2/16/2026 at 10:08 AM, the resident was observed with the following two wound dressings in place to his/her lower legs:-Left lower leg dressing dated 2/6, indicating it has been in place for 10 days, initialed by Registered Nurse (RN), Staff K, that was noted to be soiled with bloody drainage.-Right lower leg dressing dated 2/13 without any initials to indicate who applied the dressingDuring a surveyor interview immediately following the above observations with Staff J, she acknowledged the above dressings and revealed that she was going to inform the nurse about the left lower leg dressing dated 2/6. Record review failed to reveal evidence of a physician's order for the left lower leg dressing.During a surveyor interview on 2/16/2026 at 10:47 AM with RN, Staff B, she revealed that her roles are the Unit Manager and Wound Nurse. She then revealed that she was unaware that the resident had a wound to his/her left lower leg, until it was brought to the facility's attention by the surveyor.Record review revealed a wound treatment order initiated on 2/16/2026 to cleanse the open area to the left lower leg with normal saline (a wound cleanser) and apply xeroform (a wound treatment) and cover the wound with a foam dressing once daily and as needed, after the wound was brought to the facility's attention by the surveyor.During a surveyor interview on 2/18/2026 at 9:53 AM with RN, Staff K, she revealed that she was the person that identified a skin impairment to the resident's lower leg. She further revealed that she cleansed the area and placed a protective dressing over it and informed Nurse Practitioner (NP), Staff C. Further, she revealed that she did not enter or obtain a wound treatment order.During a surveyor interview on 2/19/2026 at 8:56 AM with Staff C, she revealed that she was unaware that the resident had an opened area to his/her left lower leg and would expect to have been notified when the wound was discovered.1b. During a surveyor observation in the presence of Staff J, on 2/16/2026 at 10:08 AM, the resident was observed with a dressing to his/her right lower leg dated 2/13.During a surveyor observation and simultaneous interview on 2/16/2026 at 10:32 AM with RN, Staff L, she acknowledged the resident's right lower leg dressing dated 2/13.Record review revealed a physician's order dated 2/14/2026 to cleanse his/her right lower leg skin tear with normal saline and apply a bandage every evening.Review of the February 2026 Treatment Administration Record revealed that the above wound treatment order was documented as completed on 2/14 and 2/15 by Licensed Practical Nurse, Staff F. However, the dressing was dated 2/13 indicating wound care was not provided on 2/14 or 2/15.Surveyor telephone interviews were attempted with Staff F on 2/19/2026 at 8:52 AM and 10:03 AM. Voice messages were left; however, a return call was not received.1c. Review of a policy revised December 2024 states in part, Implementation of Enhanced Barrier Precautions.Make gown and gloves available immediately near or outside of the resident's room.PPE for enhanced barrier precautions is only necessary when performing high-contact care activities.Enhanced barrier precautions should be used.until the resolution of the wound.During a surveyor observation in the presence of Staff J on 2/16/2026 at 10:08 AM, the resident was observed with the following two wound dressings in place to his/her lower legs:-Left lower leg dressing dated 2/6 initialed by Staff K-Right lower leg dressing (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 2/13Additional observation failed to reveal gowns and gloves immediately near or outside the resident's room.During a surveyor interview following the above observation with Staff J, she revealed that she had just finished completing the resident's personal care. Additionally, she revealed that she does not utilize a gown when providing personal care for the resident unless it is indicated to do so. Further, she acknowledged that there was no EBP sign or PPE outside of the resident's room.Record review failed to reveal evidence that the resident was on EBP related to his/her leg wounds.During a surveyor interview on 2/16/2026 at 10:47 AM with Staff B, she revealed that the resident is not currently on EBP and should be.During a surveyor observation following the above interview with Staff B, she was observed placing the resident on EBP after it was brought to the facility's attention by the surveyor.During a surveyor interview on 2/18/2026 at 1:16 PM with the Director of Nursing Services, she was unable to provide evidence that the facility provided appropriate treatment and services relative to wound care including initiating timely treatments, initiating appropriate transmission-based precautions, and accurately documenting wound care as being provided.Cross reference F 842

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415004	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal of Westerly Nursing Center	79 Beach Street Westerly, RI 02891

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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on surveyor observation, clinical record review, and staff interview, the facility failed to maintain medical records that are accurately documented, in accordance with professional standards and practices, for 1 of 3 residents reviewed with skin impairments, Resident ID #14.Findings are as follows:Record review revealed the resident was admitted to the facility in December of 2023 with a diagnosis including, but not limited to, stroke.Review of a physician's order dated 2/14/2026 revealed to cleanse the resident's right lower leg skin tear with normal saline and apply a bandage every evening.During a surveyor observation and simultaneous interview on 2/16/2026 at 10:32 AM with Registered Nurse, Staff L, she acknowledged the resident's right lower leg dressing was dated 2/13, indicating it had not been changed on 2/14 or 2/15.Review of the February 2026 Treatment Administration Record revealed that the above wound treatment order was documented as completed on 2/14 and 2/15 by Licensed Practical Nurse, Staff F.Surveyor telephone interviews were attempted with Staff F on 2/19/2026 at 8:52 AM and 10:03 AM. Voice messages were left; however, a return call was not received.During a surveyor interview on 2/18/2026 at 1:16 PM with the Director of Nursing Services, she was unable to provide evidence that medical records are accurately documented and maintained.Cross reference F 684