STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415008	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwood Center	1139 Main Avenue Warwick, RI 02886

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident and staff interviews, it has been determined that the facility failed to keep residents free from physical and verbal abuse for 2 of 4 residents reviewed, Resident ID #s 2 and 3.Findings are as follows:Review of a facility policy titled, Abuse Prohibition, last updated 10/24/2022, states in part, Centers prohibit abuse, mistreatment, neglect, misappropriation of resident/patient property, and exploitation for all patients.Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury, or mental anguish.verbal abuse is any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to patients or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability.Review of a facility reported incident submitted to the Rhode Island Department of Health on 9/5/2025 revealed that Certified Nursing Assistant (CNA), Staff A, appeared to be intoxicated and unfit for duty. Additionally, the incident report revealed that Staff A was witnessed being verbally abusive to residents and was rough with them while performing care.1. Record review revealed that Resident ID #2 was readmitted to the facility in May of 2023 with diagnoses including, but not limited to, schizophrenia and bipolar disorder.Record review revealed a Brief Interview for Mental Status (BIMS) Evaluation dated 9/5/2025 with a score of 99 indicating severe cognitive impairment.Review of a progress note dated 9/4/2025 authored by the Director of Nursing Services (DNS), states in part, Resident complained and calling out in pain during ADL [activities of daily living] care. [Staff A] was witnessed by [CNA, Staff B] being rough while performing ADL care. CNA assisted with care and reported event to supervisor .Resident screaming out 'You're hurting me' during care.During a surveyor interview on 9/11/2025 at 12:41 PM via telephone with CNA, Staff B, she revealed that she witnessed Staff A being aggressive while changing the resident, she pushed the resident onto his/her side in a rough manner and the resident was yelling, you're hurting me. Additionally, she revealed that another staff member, Licensed Practical Nurse (LPN), Staff C, came into the room while Staff A was being rough. Staff B further revealed that Staff A said to the resident, [Resident ID #2] you're too heavy, you need to stop eating.During a surveyor interview on 9/11/2025 at 1:30 PM with LPN, Staff C, she revealed that she witnessed Staff A, being aggressive and manhandling Resident ID #2 during a transfer and then again while changing him/her. Additionally, she revealed that Resident ID #2 was heard yelling ow you're hurting me.2. Record review revealed that Resident ID #3 was readmitted to the facility in January of 2025 with diagnoses including, but not limited to, stroke and anxiety.Review of a Minimum Data Set assessment dated [DATE] revealed a BIMS score of 15, indicating intact cognition.Review of a progress note dated 9/4/2025 authored by the DNS revealed that Staff B witnessed Staff A, verbally abusing Resident ID #3 stating s/he is a disgusting b*tch. During a surveyor interview on 9/11/2025 at 11:40 AM with Resident ID #3, s/he revealed that Staff A was not nice to him/her and refused to help him/her when s/he asked.Review of a facility provided statement authored by Registered Nurse (RN) Staff D, dated 9/5/2025 states in part, [Staff A] told [Resident #3] she wasn't changing [him/her] calling [him/her] a b*tch and that [s/he] is disgusting.During a surveyor interview on 9/11/2025 at 1:30 PM with LPN, Staff C, she revealed that she witnessed Staff A walk out of Resident ID #3's room and stated, that stupid b*tch. Additionally, she revealed that Staff A refused to assist Resident ID #3 with care.During a surveyor interview on 9/11/2025 at 1:26 PM with the DNS she was unable to provide evidence that Resident ID #s 2 and 3 were kept free from abuse.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it has been determined that the facility failed to immediately put effective measures in place to prevent further potential abuse, neglect or mistreatment of residents from occurring, following incidents where staff members observed another staff member verbally and/or physically abuse residents for 2 of 2 residents reviewed who were subjects of abuse by a staff member, Resident ID #s 2 and 3.Findings are as follows:Review of a facility policy titled, Abuse Prohibition last updated 10/24/2022 states in part, .Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately.The employee alleged to have committed the act of abuse will be immediately removed from duty, pending investigation.Review of a facility policy titled, Substance Abuse and Alcohol Misuse Prevention and Testing last updated 7/1/2022 states in part, .Genesis and its affiliates are committed to achieving a safe and healthy work environment, free from drug and alcohol abuse. Company policy strictly prohibits.drugs.alcohol, or controlled substances while on the job or on company property. Violation of such is a dischargeable offense.Review of a facility reported incident submitted to the Rhode Island Department of Health on 9/5/2025 revealed that Certified Nursing Assistant (CNA), Staff A, appeared to be intoxicated and unfit for duty. Additionally, the incident revealed that Staff A was witnessed being verbally abusive to residents and was rough while performing care.1. Record review revealed that Resident ID #2 was readmitted to the facility in May of 2023 with diagnoses including, but not limited to, schizophrenia and bipolar disorder.Record review revealed a Brief Interview for Mental Status (BIMS) Evaluation dated 9/5/2025 with a score of 99 indicating severe cognitive impairment.Review of a progress note dated 9/4/2025 authored by the Director of Nursing Services (DNS), states in part, Resident complained and calling out in pain during ADL [activities of daily living] care. [Staff A] was witnessed by [CNA, Staff B] being rough while performing ADL care. CNA assisted with care and reported event to supervisor .Resident screaming out 'You're hurting me' during care.During a surveyor interview on 9/11/2025 at 12:41 PM via telephone with CNA, Staff B, she revealed that Staff A appeared to be confused at the beginning of the shift and was unable to understand what patient assignment she was responsible for. Additionally, she revealed that after Staff A went on her lunch break between 7:00 PM and 8:00 PM when she returned, she appeared to be intoxicated, yelling in the hallways, talking to herself and nodding off. Staff B also revealed that she witnessed Staff A being aggressive while changing Resident ID #2. Furthermore, she revealed that she witnessed Staff A push Resident ID #2 on his/her side in a rough manner. Additionally, the resident was yelling, you're hurting me. She revealed that another staff member, Licensed Practical Nurse (LPN), Staff C, came into the room while Staff A was being rough with the resident. Staff B further revealed that Staff A said to the resident, [Resident ID #2] you're too heavy, you need to stop eating. Staff B revealed that she reported this incident to Registered Nurse, Staff D however, Staff A did not leave the unit until close to the end of her scheduled shift (11:00 PM).During a surveyor interview on 9/11/2025 at 1:30 PM with LPN, Staff C, she revealed that she observed Staff A at the beginning of the shift (3:00 PM), and she appeared off and as the shift went on, she began acting out including, losing her balance, nodding off and walking up and down the hallway slapping her hands on her hips. Staff C further revealed that she witnessed Staff A, being aggressive and manhandling Resident ID #2 during a transfer and then again while changing him/her. Additionally, she revealed that Resident ID #2 was heard yelling ow you're hurting me. Staff C acknowledged that she reported this incident to RN, Staff D; however, Staff A did not leave the unit until near the end of her scheduled shift.2. Record review revealed that Resident ID #3 was readmitted to the facility in January of 2025 with diagnoses including, but not limited to, stroke and anxiety.Review of a Minimum Data Set assessment dated [DATE] revealed a BIMS score of 15, indicating intact cognition.Review of a progress note dated 9/4/2025 authored by the DNS revealed that Staff B witnessed Staff A, verbally abusing Resident ID #3 stating s/he is a disgusting b*tch.During a surveyor interview on 9/11/2025 at 11:40 AM with Resident ID #3, s/he revealed that Staff A was not nice to him/her and refused to help him/her when s/he asked.During a surveyor interview on 9/11/2025 at 1:30 PM with LPN, Staff C, she revealed that she witnessed Staff A walk out of Resident ID #3's room and she said, that stupid b*tch and refused to perform care on him/her.Review of a facility provided statement authored by Registered Nurse (RN) Staff D, dated 9/5/2025 revealed that it was reported to her by Staff B that Staff A was heard calling residents names including, b*tch, disgusting and