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	12/12/2025

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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 0760 Level of Harm - Actual harm Residents Affected - Few	Based on clinical record review and staff interview, the facility failed to ensure that residents are free of any significant medication errors for 1 of 1 resident reviewed who did not receive his/her Lispro (a medication prescribed to treat elevated blood sugar levels), as ordered, Resident ID #1. The failure to administer 17 out of 17 prescribed doses resulted in elevated blood glucose levels and contributed to the resident's clinical decline, including lethargy and critically elevated blood glucose levels, requiring transfer to an acute care hospital. Findings are as follows:Record review of a community reported complaint submitted to the Rhode Island Department of Health on 12/9/2025, alleges in part, the resident who was discharged from the hospital returned within a week because the facility failed to accurately check the sugar levels. Additionally, the report revealed the resident was readmitted to the hospital with a glucose (blood sugar) level of 793 at arrival (normal blood glucose levels for diabetics are between 80 and 130 mg/dL (milligram/deciliter).Review of a facility policy dated 1/2023, titled Medication Administration Subcutaneous Insulin [a method of delivering insulin into the fatty tissue just below the skin with a needle] states, to administer subcutaneous insulin as ordered and in safe, accurate and effective manner. Record review revealed Resident ID #1 was admitted to the facility in November of 2025 with diagnoses including, but not limited to, end stage renal disease (kidney disease) and dysphagia (difficulty swallowing).Review of a physician's order dated 11/24/2025 revealed an order for Insulin Lispro 3 units, to be administered subcutaneously, three times daily at 9:00 AM, 1:00 PM, and 6:00 PM, beginning on 11/25/2025.Review of the November 2025 Medication Administration Record failed to reveal evidence that Resident ID #1 received Insulin Lispro, as ordered, on the following dates and times: - 11/25/2025 at 9:00 AM, 1:00 PM, and 6:00 PM - 11/26/2025 at 9:00 AM, 1:00 PM, and 6:00 PM - 11/27/2025 at 9:00 AM, 1:00 PM, and 6:00 PM - 11/28/2025 at 9:00 AM, 1:00 PM, and 6:00 PM - 11/29/2025 at 9:00 AM and 6:00 PM - 11/30/2025 at 9:00 AM, 1:00 PM, and 6:00 PMThis indicates that the resident missed a total of 17 out of 17 prescribed doses of Insulin Lispro from 11/25/2025 through 11/30/2025.Record review further revealed elevated blood glucose levels on the following dates: - 11/25/2025 - 285 - 11/26/2025 - 385 - 11/27/2025 - 250 - 11/28/2025 - 278 - 11/29/2025 - 247 - 11/30/2025 - 218 - 12/1/2025 - 582 and 483 - 12/2/2025 - 394 and 542 - 12/3/2025 - 484Record review of a progress note dated 12/3/2025 revealed, the resident was lethargic, with a low blood pressure and an elevated heart rate. The provider ordered for a complete blood count to be obtained which revealed a critically elevated blood glucose level of 658 mg/dL. During a surveyor interview on 12/9/2025 at 2:55 PM, with Licensed Practical Nurse, Staff A, she revealed she was the resident's assigned nurse during the period of 11/25/2025 through 11/30/2025. Staff A revealed that she does not remember administering the insulin lispro. Further, she indicated that the resident was transferred to an acute care hospital for lethargy and a blood sugar level over 600 on 12/3/2025. During a surveyor interview on 12/9/2025 at 3:51 PM, and 12/10/2025 at 10:16 AM, with the Director of Nursing Services, she was unable to provide evidence that the resident received the Insulin Lispro on the above-mentioned dates, as ordered.During a surveyor interview on 12/12/2025 at 12:46 PM, with the Nurse Practitioner, she indicated that she would expect the staff to follow the provider's orders.Based on the above findings, the facility failed to ensure that Resident ID #1 received Insulin Lispro, as ordered, in accordance with physician's orders and facility policy. The failure to administer 17 out of 17 prescribed doses resulted in persistently elevated blood glucose levels and contributed to the resident's clinical decline, including lethargy and critically elevated blood glucose levels, ultimately requiring transfer to an acute care hospital.