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	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwood Operations Dba 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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, and staff and resident interviews, the facility failed to protect and promote the rights of residents relative to preferences and privacy, for 2 of 3 residents reviewed, Resident ID #s 2 and 3.Findings are as follows:Review of the facility policy titled, Resident Rights Under Federal Law, states in part, .To treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of their self-esteem and self-worth.To incorporate the resident's goals, preferences, and choices into care. 1. Record review of a facility reported incident submitted to the Rhode Island Department of Health on 1/13/2026 revealed that Resident ID #2 reported that a Nursing Assistant (NA), Staff A, was rude while providing care and not following preferences despite the resident attempting to express his/her needs. The report further revealed that the resident hit his/her head on the side rail when the NA rolled him/her to the side to provide care. Additionally, the resident was found to have a bruise above his/her left eyebrow.Record review revealed that the resident was admitted to the facility in December of 2024 with diagnoses including, but not limited to, muscle weakness and osteoarthritis.Review of the Minimum Data Set (MDS) Assessment revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating moderately impaired cognition. Further review revealed the resident is alert and oriented to person, place, and time. Additional review revealed the resident is dependent on staff for activities of daily living (ADLs), including rolling from side to side while in bed.Review of a care plan dated 12/19/2024 revealed the resident requires assistance with ADLs with interventions including, but not limited to, providing cueing for safety and to maximize current level of functioning, and that bed rails are used as an enabler for repositioning.Review of the SBAR [situation, background, assessment and recommendations] Communication Form completed by the Director of Nursing Services (DNS) dated 1/13/2026, revealed the resident was tearful following an alleged event involving a NA who was rude and not following the resident's preferences for care. Further review revealed the resident reported that s/he hit his/her head on the bed side rail when an NA turned the resident. A small faint bruise was found above the resident's left eyebrow. Review of the January 2026 Medication Administration Record revealed the resident received acetaminophen for head pain on 1/13/2026, following the alleged incident.During a surveyor interview on 2/11/2026 at 12:37 PM with Resident ID #2, s/he indicated that Staff A wasn't listening to how s/he is safely rolled from side to side in the bed and because of this, s/he hit his/her head on the side rail. The resident further indicated that Staff A refused to close his/her privacy curtain during care which was bothersome because his/her roommate has to walk by his/her bed to get to the bathroom.During a surveyor interview on 2/11/2026 at approximately 12:45 PM with Resident ID #2's roommate, s/he indicated that s/he was in the room during the alleged incident and heard Staff A speaking rudely to Resident ID #2. S/he further indicated that s/he heard Resident ID #2 yell ouch and was concerned about how s/he was being (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 0550 Level of Harm - Actual harm Residents Affected - Few	treated. Additionally, the s/he confirmed that the privacy curtain was open while Staff A was providing care to Resident ID #2.Staff A was called by the surveyor on 2/11/2026 at approximately 11:30 AM; a voice mail was left; however, no return phone call was received.During a surveyor interview on 2/11/2026 at 12:04 PM and at 2:02 PM with the DNS, she indicated that she assessed Resident ID #2 following the allegation of mistreatment and found a faint bruise above his/her left eyebrow, that was approximately the size of a quarter. 2. Review of a facility policy titled Pets/Animal Visits last revised 5/1/2025 states in part, .Patients must be asked if they would like to visit or interact with the animal.Review of a community reported complaint submitted to the Rhode Island Department of Health on 2/3/2026 alleges that a dog was brought into a common area of the facility, which triggered panic and anxiety for a resident. The complaint further alleges that the resident requested that the dog be removed from the common area, however the visitor initially did not remove the dog. Further, the complaint alleges that a staff member indicated that pets are allowed in the facility and that the resident should remove him/herself from the common area if s/he is uncomfortable.Record review revealed Resident ID #3 was admitted to the facility in April of 2025.Review of the MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, indicated intact cognition.During a surveyor interview on 2/11/2026 at 12:56 PM with Resident ID #3, s/he indicated that dogs have created extreme anxiety and panic since s/he was a child. The resident further indicated that another resident's wife brought a dog into a common area unannounced which caused him/her to panic. Additionally, the resident indicated that the Director of Social Services told him/her that s/he would have to leave the common area if s/he felt uncomfortable about the dog, and that the situation would not be discussed any further. During a surveyor interview on 2/11/2026 at approximately 1:45 PM with the Director of Social Services, she indicated that she told Resident ID #3 that s/he would have to leave the common area if s/he had a problem with a dog because residents have the right to enjoy the dogs that are brought in. She further indicated that she did not allow the conversation to continue with the resident.During a surveyor interview on 2/11/2026 at 2:06 PM with the DNS, she indicated that pets are allowed into the facility and if several residents were uncomfortable with a dog in the common area, the dog would be removed, but if one resident was uncomfortable with a dog then that resident would be removed. Additionally, she could not provide evidence that the facility protected and promoted the rights of Resident ID #s 2 and 3.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to ensure medications were administered as ordered. Additionally, the facility failed to recognize a change in condition in a timely manner for 1 of 1 resident reviewed, who was transferred to the hospital by a non-medical transport company, after being found by facility staff to have experienced a change in mental status, a decrease in oxygen saturation levels, and who subsequently expired, Resident ID #1.Findings are as follows:Record review of a community reported complaint submitted to The Rhode Island Department of Health on [DATE] alleges that this facility provided Neglectful transport of a patient in a non medical transport vehicle during [an] acute medical emergency.Review of a facility policy last revised [DATE] titled Change in Condition: Notification of states in part, .A Center must immediately inform the patient, consult with the patient's physician, and notify.the patient's representative, where there is.A significant change in condition in the patients physical, metal, or psychosocial status.A need to alter treatment significantly.To provide appropriate and timely information about changes relevant to the patient's condition. Record review revealed the resident was admitted to the facility on [DATE] with a diagnosis including, but not limited to, a urinary tract infection (UTI).Review of the care plan dated [DATE] revealed the resident has a UTI with interventions including, but not limited to, screen the resident for sepsis (a life threatening condition caused by an infection) and report a positive screen to a physician .2 or more of the following.Pulse [great than] 100.Respiratory rate [greater than] 20 or [oxygen saturation] 90% .Altered Mental Status- change in eye/speech/motor response.Report to physician any changes in.[vital signs] and/or condition (including subtle changes).Review of the hospital Discharge summary dated [DATE] indicated the resident was to receive Meropenem (an antibiotic) 1 gram (g) in 50 milliliters (mL) of normal saline, intravenously every eight hours for six days. Further review revealed the resident was alert and oriented to person, place, and time, and was receiving 1 liter (L) of oxygen via a nasal cannula (a thin flexible tube that is used to administer oxygen through the nose).Record review failed to reveal evidence that three scheduled doses of the Meropenem were administered as ordered.Record review failed to reveal evidence that the provider was notified that the resident had missed three doses of the antibiotics as prescribed. Record review of the progress notes revealed the resident was receiving oxygen (O2) via nasal cannula at 1 L to maintain oxygen saturation. Record review of a progress note dated [DATE] at 10:52 PM states in part, .Resident is alert and oriented x 3 . O2 91% .oxygen via nasal canula. [pulse] 96 .During a surveyor interview on [DATE] at 12:26 PM with Registered Nurse (RN), Staff B, she stated that she was assigned to the resident during the 11:00 PM to 7:00 AM shift from [DATE] into [DATE]. She revealed that she found the resident confused and attempting to get out of bed with the nasal cannula removed. She further stated the resident was short of breath with decreased oxygen saturation. Staff B stated she was unable to recall what the resident's oxygen saturation level dropped to, but she revealed that she increased the oxygen flow to 4 liters and the resident's oxygen saturation level improved. Additionally, Staff B revealed that she did not notify the provider because she did not think that this situation was a change in condition; she was unaware of the resident's baseline (typical or usual state of health) stating, I don't know, the resident could have had a diagnosis of hypoxia (an abnormally low oxygen saturation level) . She also stated that she informed the oncoming nurse to keep an eye on the resident prior to leaving the facility that morning. Lastly, Staff B ended the interview by denying that she had stated to the surveyor that the resident was confused upon her assessment. Record review failed to reveal evidence that Staff B documented in the clinical record or communicated to the (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	oncoming staff that the resident was found without his/her nasal cannula on, required an increase in oxygen flow to achieve a normal oxygen saturation level, and was trying to get out of bed unassisted. Further record review revealed the following progress notes, authored by the oncoming RN, Staff C, who was informed by Staff B to keep an eye on the resident prior to leaving the facility on the morning of [DATE]: - [DATE] at 8:34 AM- Change to patient's baseline. Decrease in alertness, not able to follow simple commands or form words. [Vital Signs]: [blood pressure] 119/94, [heart rate] 126, [respiratory rate] 20, [oxygen saturation] 93% increased to 4 L. Spoke with .NP; patient to be sent to [emergency department] for evaluation. Transport arranged with EFG [a non-medical transportation company]. Patient's daughter [name redacted] notified and requested that patient be transferred to TMH [The [NAME] Hospital]. - [DATE] at 10:05 AM- .TMH called in to voice concern on non-medical transport for patient.Review of the Continuity of Care Acute Care Transfer Form dated [DATE], completed by Staff C, revealed the resident was unable to form sentences, required increased oxygen, was unable to follow simple commands, and was experiencing a mental status change.During a surveyor interview on [DATE] at approximately 10:40 AM with RN, Staff C, she revealed that on the morning of [DATE], the 3rd shift nurse, Staff B, had told her in report to keep an eye on [Resident ID #1] because his/her oxygen saturation had decreased into the 80's (a normal range from 95-100%) and the oxygen flow was increased from 1 L to 4 L. She further indicated that when she went in to assess the resident at approximately 8:00 AM, she noted the resident to have a decreased level of alertness and notified the nurse practitioner (NP). Additionally, she indicated that the resident was ordered to be sent out and the decision was made with the Unit Manager, Staff F, another RN on the unit, Staff D, and the Nurse Practitioner Staff E, to send the resident to the hospital via a non-medical transport.The surveyor attempted to contact Staff B, a voice mail was left; however, no return phone call was received.During a surveyor interview on [DATE] at 1:30 PM with NP, Staff E, she revealed that she was notified of the resident's change of condition, including an altered mental status and a decrease in oxygen saturation, on the morning of [DATE] and ordered the resident to be sent to the hospital for an evaluation. She further revealed that she received a verbal report of the resident's change in condition, but never assessed the resident on [DATE]. Additionally, she indicated that she would've expected the resident to be transported to the hospital for an evaluation per the facility's policy pertaining to the method of transportation that is indicated during a situation such as this.On [DATE] at 1:42 PM a policy was requested regarding transporting a resident to the hospital due to a change in condition, but was informed by the DNS that the facility did not have a policy pertaining what type of transportation is indicated when a resident is experiencing a change in condition. The DNS revealed that the mode of transportation is a clinical decision.Record review of the hospital documentation dated [DATE] revealed the resident arrived at the hospital via non-medical transportation with altered mental status, shortness of breath, and severe hypoxia. The report further indicated that the resident was found to have hypercarbic hypoxic respiratory failure (a condition where the body has too much carbon dioxide and not enough oxygen in the blood), sepsis, and influenza. Additional review revealed the resident was transitioned to comfort measures and expired at the hospital later that day. During a surveyor interview on [DATE] at 10:06 AM with the Medical Director, he indicated that he would have expected that the IV antibiotics to be administered as ordered or that a provider would be notified of the missed doses. He further indicated that he would expect a decrease in oxygen saturation to be identified as a change in condition and that a provider would be notified. Additionally, he indicated that he would expect emergency medical services to transport a resident who is experiencing a change of condition that includes, a change in metal status and a decrease in oxygen (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	saturation. The Medical Director further revealed that he was informed that the family of this resident refused emergency medical services to transport resident because they wanted him/her to go to a particular hospital. During a surveyor interview on [DATE] at approximately 2:00 PM with the Director of Nursing Services, she indicated that the resident's family member chose non-medical transportation to ensure that the resident would be transported to a particular hospital. She further indicated that the family member had been educated that the non-medical transport could not provide any medical support during the transportation.During a surveyor interview on [DATE] at approximately 12:30 PM with the resident's family member, s/he stated that s/he did not choose the mode of transportation and was unaware that the resident was transferred to the hospital via a non-medical transport. S/he further indicated that s/he thought the transporters were emergency medical technicians (EMTs). Additionally, s/he was not informed by the facility that his/her request to transport the resident to a particular hospital meant that the resident's condition would not be monitored during the transfer to the hospital. Furthermore, s/he revealed that s/he was not made aware that the resident had missed doses of the antibiotic. The facility's failure to administer antibiotics as ordered, identify and report the resident's change in condition in a timely manner to a provider, to not transport the resident emergently to a hospital after being found by facility staff to have experienced a change in mental status and a decrease in oxygen saturation levels, where s/he was diagnosed with sepsis and expired later that day, placed the resident at risk for serious injury, serious harm, serious impairment or death. Cross reference F 695, F 726, F 760 and F 842

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to provide respiratory care consistent with professional standards of practice for 1 of 1 resident reviewed who required oxygen therapy, Resident ID #1.Findings are as follows:According to Brunner and Sudarth's textbook, Medical and Surgical Nursing, 7th Edition, 1992, p. 524, as with other medications, oxygen is administered with care, and its effects on each patient are carefully assessed. Oxygen is a drug and except in emergency situations is prescribed by a physician.Record review revealed the resident was admitted to the facility on [DATE] with a diagnosis including, but not limited to, a urinary tract infection (UTI).Review of the hospital Discharge summary dated [DATE] indicated that the resident required 1 liter (L) of oxygen via nasal cannula (a thin, flexible tube that delivers oxygen through the nose).Record review of the following progress notes revealed the resident was receiving oxygen via nasal cannula:-2/5/2025 at 12:06 AM-2/5/2025 at 1:26 AM-2/6/2026 at 12:17 AM-2/6/2026 at 8:34 AMRecord review failed to reveal evidence of a physician's order for oxygen therapy.Record review failed to reveal evidence that a care plan was put into place indicating that the resident required oxygen therapy. During a surveyor interview on 2/10/2026 at approximately 10:40 AM with Registered Nurse, Staff C, she indicated that the resident was receiving oxygen via a nasal cannula since admission. She further indicated that a physician's order is usually in place if a resident requires oxygen.During a surveyor interview on 2/10/2025 at 1:42 PM with the Director of Nursing Services, she indicated that she would expect a physician's order to be in place when the resident requires continuous oxygen therapy.Cross reference F 684

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to have sufficient nursing staff with the necessary competencies and skills to provide the required nursing and related services. This failure jeopardized resident safety and hindered the attainment or maintenance of the highest practicable physical, mental, and psychosocial wellbeing of each resident. This was particularly evident in the case of four nursing staff members: Staff B, C, D, and F, where a change in a resident's condition was not properly identified.Findings are as follows:Record review of a community reported complaint submitted to The Rhode Island Department of Health on [DATE] alleges that this facility provided Neglectful transport of a patient in a non-medical transport vehicle during [an] acute medical emergency.Review of the facility policy last revised [DATE] titled, Nursing Services states in part, .Centers will have sufficient nursing staff.in accordance with state and federal regulations, with appropriate competencies and skill sets to provide nursing and related services to assure patient safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each patient, as determined by the patient assessments and individual plans of care and.in accordance with the Facility Assessment.the Center must ensure that licensed nurses have the specific competencies and skill sets necessary to care for patients' needs.A staff's ability to use and integrate knowledge and skills must be assessed and evaluated by staff already determined to be competent in these skill areas.Review of the Facility assessment dated 2025 states in part, .[NAME] Center serves a diverse population of residents whose diagnoses and conditions span low, high, and very high acuity levels.All staff are educated, trained, and competencied on hire and annually.Licensed Nursing Staff.use Point of Care (POC) or PointClickCare (PCC) to complete orders, assessments, and documentation. The documentation entered by the nursing staff triggers alerts based on the information recorded, helping to identify any decline in the resident's condition. Staff Training & Competencies Skill Set.The practices and tools used to demonstrate the ability to identify resident changes in condition . Record review revealed the resident was admitted to the facility on [DATE] with a diagnosis including, but not limited to, a urinary tract infection (UTI).Review of the care plan dated [DATE] revealed the resident has a UTI with interventions including, but not limited to, screen the resident for sepsis and report a positive screen to a physician .2 or more of the following.Pulse [great than] 100.Respiratory rate [greater than] 20 or [oxygen saturation] 90% .Altered Mental Status- change in eye/speech/motor response.Report to physician any changes in .[vital signs] and/or condition (including subtle changes).During a surveyor interview on [DATE] at 12:26 PM with Registered Nurse (RN), Staff B, she stated that she was assigned to the resident during the 11:00 PM to 7:00 AM shift from [DATE] into [DATE]. She revealed that she found the resident confused and attempting to get out of bed his/her nasal cannula removed. She further stated the resident was short of breath with decreased oxygen saturation. Staff B stated she was unable to recall what the resident's oxygen saturation level dropped to, but she revealed that she increased the oxygen flow to 4 liters and the resident's oxygen saturation level improved. Additionally, Staff B revealed that she did not notify the provider because she did not think that this situation was a change in condition; she was unaware of the resident's baseline (typical or usual state of health) stating, I don't know, the resident could have had a diagnosis of hypoxia (an abnormally low oxygen saturation level) . She also stated that she informed the oncoming nurse to keep an eye on the resident prior to leaving the facility that morning. Lastly, Staff B ended the interview by denying that she had stated to the surveyor that the resident was confused upon her assessment. Record review failed to reveal (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	evidence that Staff B documented in the clinical record or communicated to the oncoming staff that the resident was found without his/her nasal cannula on, required an increase in oxygen flow to achieve a normal oxygen saturation level, and was trying to get out of bed unassisted. Further record review revealed the following progress notes, authored by the oncoming RN, Staff C, who was informed by Staff B to keep an eye on the resident prior to leaving the facility on the morning of [DATE]: -[DATE] at 8:34 AM- Change to patient's baseline. Decrease in alertness, not able to follow simple commands or form words. [Vital Signs]: [blood pressure] 119/94, [heart rate] 126, [respiratory rate] 20, [oxygen saturation] 93% increased to 4 L. Spoke with .NP; patient to be sent to [emergency department] for evaluation. Transport arranged with EFG [a non-medical transportation company]. Patient's daughter [name redacted] notified and requested that patient be transferred to TMH [The [NAME] Hospital] .-[DATE] at 10:05 AM- .TMH called in to voice concern on non-medical transport for patient.Review of the Continuity of Care Acute Care Transfer Form dated [DATE], completed by Staff C, revealed the resident was unable to form sentences, required increased oxygen, was unable to follow simple commands, and was experiencing a mental status change.During a surveyor interview on [DATE] at approximately 10:40 AM with RN, Staff C, she revealed that on the morning of [DATE], the 3rd shift nurse, Staff B, had told her in report to keep an eye on [Resident ID #1] because his/her oxygen saturation had decreased into the 80's (a normal range from 95-100%) and the oxygen flow was increased from 1 L to 4 L. She further indicated that when she went in to assess the resident at approximately 8:00 AM, she noted the resident to have a decreased level of alertness and notified the nurse practitioner (NP). Additionally, she indicated that the resident was ordered to be sent out and the decision was made with the Unit Manager, Staff F, another RN on the unit, Staff D, and the Nurse Practitioner Staff E, to send the resident to the hospital via a non-medical transport.Record review of the hospital documentation dated [DATE] revealed the resident arrived at the hospital via non-medical transportation with altered mental status, shortness of breath and severe hypoxia (low oxygen saturation). The report further indicated that the resident was found to have hypercarbic hypoxic respiratory failure (a condition where the body has too much carbon dioxide and not enough oxygen in the blood), sepsis (a life-threatening condition caused by an infection), and influenza. Additional review revealed the resident was transitioned to comfort measures and expired at the hospital later that day. Record review failed to reveal evidence that competencies were completed related to identifying a resident's change in condition for the following nursing staff:-RN, Staff B-RN, Staff C-RN, Staff D-RN, Unit Manager, Staff FDuring a surveyor interview on [DATE] at 10:06 AM with the Medical Director, he indicated that he would expect a decrease in oxygen saturation to be identified as a change in condition and that a provider would be notified. Additionally, he indicated that he would expect emergency medical services to transport a resident who is experiencing a change of condition. During a surveyor interview on [DATE] at approximately 10:30 AM with the Director of Nursing Services, she could not provide evidence that Staff B, C, D, and F received education pertaining to identifying and addressing a resident's change in condition.The facility's failure to ensure its nursing staff are competent in identifying a resident's change in condition resulted in a delay in treatment for Resident ID #1. Additionally, the lack of competent nursing staff lead to the resident being transported non-emergently to a hospital (located approximately 20 minutes away from the facility) where s/he was diagnosed with sepsis and expired later that day. Furthermore, this failure placed the resident at risk for serious injury, serious harm, serious impairment or death. Cross reference F684 and F760

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to ensure that residents are free of any significant medication errors for 1 of 1 resident reviewed who did not receive intravenous antibiotic therapy as ordered, Resident ID #1. Findings are as follows:Record review revealed the resident was admitted to the facility on [DATE] with a diagnosis including, but not limited to, a urinary tract infection (UTI).Review of the hospital Discharge summary dated [DATE] revealed the resident was to receive Meropenem (an antibiotic) 1 gram (g) in 50 milliliters (mL) of normal saline, intravenously every eight hours for six days. Record review revealed a physician's order for Meropenem IV solution reconstituted 1 gm IV three times a day for complicated UTI, in 50 ml of normal saline until [DATE].Record review revealed Resident ID #1 missed three doses of the Meropenem IV 1 gm as ordered. During a surveyor interview with Registered Nurse (RN), Staff C on [DATE] at approximately 10:40 AM she revealed that she was unable to administer the antibiotics to the resident as it was not available. She was aware that the medication was available in the E-kit however, there were only 100 mL bags of normal saline available to reconstitute the medication so she did not give it. Additionally, she revealed that she had asked the Unit Manager, RN Staff F, how to administer the medication and was told that it couldn't be administered due to not having the correct size bag of normal saline. Lasty, Staff C revealed that the provider was notified that the resident did not receive his/her antibiotic. Further review failed to reveal evidence that the provider was notified of the missed doses of the antibiotic.During a surveyor interview on [DATE] at 9:28 AM with the Pharmacist, he acknowledged that the facility's E-kit contained Meropenem IV 1 gm, which was available for administration on [DATE]. He revealed that his expectation would have been for the facility to call the pharmacy to clarify the amount of normal saline on hand. Additionally, he indicated that he would've advised the facility to extract 50 mL of normal saline from the 100 mL bag which would have left 50 mL of normal saline for the reconstitution and the administration of the antibiotic, which would have prevented missed doses.Record review revealed the facility received a complete E-kit on [DATE].Review of the PharMerica Genesis Master E-Kit Contents List updated [DATE] revealed Meropenem IV 1 gm vial and Normal saline 100 mL, was available in the IV kit.Review of the IV E-kit utilization form failed to reveal evidence that the Meropenem or the normal saline was removed from the E-kit for administration. Review of the Electronic Shipping Manifest provided by PharMerica revealed the Meropenem and 50 ml normal saline was not delivered to the facility until [DATE] at 8:54 PM.Record review revealed the resident was sent to the hospital on the morning of [DATE] after the facility failed to administer three of five doses of the IV antibiotics as ordered.Record review of the hospital documentation dated [DATE] revealed the resident arrived at the hospital by a non-medical transportation company with altered mental status, shortness of breath, and severe hypoxia (low oxygen saturation). The report further indicated that the resident was found to have hypercarbic hypoxic respiratory failure (a condition where the body has too much carbon dioxide and not enough oxygen in the blood), sepsis (a life-threatening condition caused by an infection), and influenza. Additional review revealed that the resident was transitioned to comfort measures and expired at the hospital later that day. During a surveyor interview on [DATE] at 10:06 AM with the Medical Director, he indicated that he would expect nursing to reach out to the pharmacy for clarification and instructions. He further indicated that he would've expected the Meropenem IV 1 gm to have been removed from the E-kit and administered as ordered. During a surveyor interview on [DATE] at approximately 11:30 AM with the Director of Nursing Services, she acknowledged that the Meropenem IV 1 gm was available in the E-kit with 100 mL of normal saline. Additionally she acknowledged that the (continued on next page)

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	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwood Operations Dba 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	resident missed three doses of the Meropenem and could not provide evidence that a provider was notified of the missed doses. The facility's failure to administer antibiotics as ordered, resulted in the resident being transferred to the hospital where s/he was diagnosed with sepsis. Cross reference F 684, F 726 and F842

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	02/18/2026

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

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure that resident records are complete and accurately documented, relative to medication administration for 1 of 1 resident reviewed who did not receive intravenous antibiotic therapy as ordered, Resident ID #1. Findings are as follows:Record review revealed the resident was admitted to the facility on [DATE] with a diagnosis including, but not limited to, a urinary tract infection (UTI).Record review revealed a physician's order for Meropenem IV solution reconstituted 1 gm IV three times a day for complicated UTI, in 50 mL of normal saline until 2/10/2026.Record review revealed the facility received a complete E-kit on 2/4/2026.Review of the PharMerica Genesis Master E-Kit Contents List last revised 3/3/2025 revealed, Meropenem IV 1 gm vial and normal saline 100 mL was available in the IV kit.Review of the IV E-kit utilization form failed to reveal evidence that the Meropenem or the normal saline were removed from the E-kit for administration. Review of the Electronic Shipping Manifest provided by PharMerica revealed the Meropenem and 50 ml of normal saline was not delivered to the facility until 2/5/2026 at 8:54 PM.Record review revealed Resident ID #1 missed three doses of the Meropenem IV 1 gm as ordered.Record review of the February 2026 Medication Administration Record (MAR) revealed Meropenem IV 1 gm was signed as administered on 2/4/2025 at 10:00 PM and on 2/5/2025 at 6:00 AM, when it had not been administered to resident.During a surveyor interview on 2/11/2026 at approximately 11:30 AM with the Director of Nursing Services, she acknowledged that the Meropenem IV 1 gm was available in the E-kit with 100 mL of normal saline and that it was not administered to the resident until it was delivered by the pharmacy on the evening of 2/5/2026. Additionally, she could not provide evidence that the resident's MAR was accurately documented to reflect that the resident had missed a total three doses of the Meropenem. Cross reference F 760