STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41729 43987 47279 Based on surveyor observation, record review, staff and resident representative interviews, it has been determined that the facility failed to ensure that a resident's right to communication and access to persons and services inside and outside the facility to promote a dignified existence was promoted for 2 of 2 residents reviewed whose primary language is not English, Resident ID #s 16 and 52. Findings are as follows: Review of the Facility Assessment document states in part, .[the facility's] nursing team takes a resident-centered approach that respects cultural, ethnic, and linguistic preferences, ensuring that each resident receives care tailored to their identity and values. This includes .Linguistic support .[the facility] accommodates residents with limited English proficiency .by providing .support for multiple languages .The Recreation Department .continuously adapted to reflect the changing demographics and cultural preferences of the residents .to ensure inclusivity and meaningful engagement for all residents . 1a) Record review revealed Resident ID #16 was admitted to the facility in July of 2024 with a diagnosis including, but not limited to, dementia. Additionally, s/he resides on the second floor, East Unit. Review of his/her care plan revealed a focus area dated 7/26/2024 indicating that s/he has impaired communication due to a language barrier. Additionally, it failed to indicate what the resident's primary language is. During a surveyor observation on 3/5/2025 at approximately 10:30 AM, staff members of the Activities Department were observed distributing a newsletter written in English titled, THE DAILY CHRONICLE to the residents on the second floor, East Unit. Resident ID #16 was not observed to have received a copy of the newsletter. During a surveyor interview on 3/5/2025 at 11:11 AM with Registered Nurse, Staff A, she revealed that the Activities Department distributes the newsletter daily to the residents. (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 - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 3/5/2025 at 11:15 AM with the Activity Director, she revealed that Resident ID #16's primary language is Khmer (a dialect of Cambodian). She further revealed that the newsletter is only available in English, Spanish, and French. She was unable to provide evidence that Resident ID #16 received the newsletter, or received the newsletter in a language that s/he understands. b) Record review revealed Resident ID #52 was admitted to the facility in May of 2023 with a diagnosis including, but not limited to, dementia. Additionally, s/he resides on the second floor, East Unit. Review of his/her care plan revealed a focus area dated 6/6/2023 indicating that his/her primary language is Chinese. During a surveyor observation on 3/5/2025 at approximately 10:30 AM, staff members of the Activities Department were observed distributing a newsletter written in English titled, THE DAILY CHRONICLE to the residents on the second floor, East Unit. Resident ID #52 was not observed to have received a copy of the newsletter. During a surveyor interview on 3/5/2025 at 11:15 AM with the Activity Director, she was unable to provide evidence that Resident ID #52 received the newsletter, or received the newsletter in a language that s/he can fully understand. During a surveyor interview on 3/5/2025 at 11:31 AM with Resident ID #52's representative, who is fluent in both English and Resident ID #52's primary language, s/he revealed that the resident speaks Mandarin (a dialect of Chinese). Utilizing Resident ID #52's representative as a mode to communicate, Resident ID #52 indicated that s/he does not understand the staff and has difficulty communicating because the staff only use English. Additionally, the resident revealed that s/he would like to receive the newsletter in a language that s/he can understand. During a surveyor interview on 3/5/2025 at 3:34 PM with the Director of Nursing Services, she revealed that Resident ID #s 16 and 52 sometimes receive the newsletter, but in English. Additionally, she revealed that she would expect that all residents receive the newsletter in a language that they can fully understand. During a subsequent interview on 3/6/2025 at 10:52 AM with the Activity Director and Resident ID #52's representative, in the presence of Resident ID #52, the Activity Director revealed that she was able to translate the newsletter into the resident's primary language and indicated that the resident received a copy after the concern was brought to the facility's attention by the surveyor. Additionally, Resident ID #52's representative revealed that the resident was happy to receive the newsletter, and was able to fully understand it.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41729 Based on record review and staff interview, it has been determined that the facility failed to ensure that residents' advance directives were consistent with the resident's electronic medical record (EMR) for 2 of 2 residents reviewed in which their advance directive copies did not match the EMR, Resident ID #s 16 and 154. Findings are as follows: 1. Record review revealed Resident ID #16 was readmitted to the facility in October of 2024 with a diagnosis including, but not limited to, acute respiratory failure. Record review revealed a Medical Orders for Life Sustaining Treatment (MOLST) form signed by the resident's representative and dated [DATE] which indicates, Do Not Attempt Resuscitation/DNR Allow Natural Death . Record review of a document titled Clinical Resident Profile states in part, .Code Status: Advance Directive/Full Code [Cardiopulmonary Resuscitation/CPR is to be performed if there is no pulse and respiration]. Review of Resident ID #16's care plan dated [DATE] revealed the resident is a full code. During a surveyor interview with Registered Nurse, Staff B, on [DATE] at 9:08 AM, she acknowledged that the resident's EMR was not consistent with the advance directive documented on the MOLST form. Additionally, Staff B indicated that if there was an emergency, she would treat the resident as a full code. 2. Record review revealed Resident ID #154 was admitted to the facility in February of 2025 with a diagnosis including, but not limited to, acute respiratory failure. Record review revealed a MOLST form signed by the resident and dated [DATE] which indicates, Attempt Resuscitation/CPR. Record review of a physician's order dated [DATE] revealed the resident is a DNR. Review of Resident ID #154's care plan dated [DATE] revealed the resident is a DNR. Record review failed to reveal evidence that the resident had changed his/her code status to a DNR after s/he had signed the MOLST form on [DATE], indicating s/he wants to be a full code. During a surveyor interview on [DATE] at 9:50 AM, with the Nurse Practitioner (NP) who had signed the MOLST form dated [DATE], she acknowledged that Resident ID #154 had signed the MOLST form as a full code. The NP acknowledged that the resident had not changed his/her code status to a DNR, as indicated in the physician's order dated [DATE]. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During surveyor interviews with the Director of Nursing Services (DNS) on [DATE] at 11:47 AM and on [DATE] at 9:38 AM, she indicated that she would expect the residents' MOLST forms reflecting the residents' wishes to be consistent with the EMR. Additionally, the DNS was unable to provide evidence why there were inconsistencies in the residents' records.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41729 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that the residents' environment remains free from accident hazards relative to appropriately disposing of hazardous materials for 1 of 2 medication carts observed, One-North medication cart. Findings are as follows: Review of the facility's policy titled Safety and Health Policies and Procedures: Needle Handling and Sharps Injury Prevention dated 4/15/2024, states in part, .Sharps Disposals: Contaminated sharps [are medical devices with sharp points or edges that can puncture or cut skin such as needles, syringes, lancets] will be discarded immediately in appropriate disposal containers . During a surveyor observation of the One-North medication cart on 3/4/2025 the following was revealed: - At 10:25 AM-10:30 AM, two used lancets (a small needle device used to prick the skin to draw blood for testing) and a glass vial were observed on the top surface of a biohazardous waste container (a specialized container designed for the safe storage and disposal of materials that pose a threat of infection or contamination) which were visible and accessible to residents. - At 11:38 AM -11:47 AM, three used lancets, a used syringe with a needle attached, and a glass vial were observed on the top surface of the biohazardous waste container which were visible and accessible to residents. During these observations, there were no staff at the medication cart or in proximity of the cart. Multiple residents were observed in proximity to the cart. During a surveyor observation and interview on 3/4/2025 at approximately 11:50 AM with Registered Nurse, Staff D, she acknowledged the 3 lancets, a syringe with a needle attached, and a glass vial were on the top of the biohazardous waste container. Staff D acknowledged the above-mentioned items were not disposed appropriately. During a surveyor interview on 3/4/2025 at 1:43 PM with the Director of Nursing Services, she indicated that she would expect all sharps material including the above-mentioned items to be disposed of in the biohazardous waste container and not on the top surface, as observed.

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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 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. 41729 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide respiratory care consistent with professional standard of practice for 2 of 3 residents reviewed for oxygen use, Resident ID #s 24 and 154. Findings are as follows: According to Lippincott Nursing Procedure Ninth Edition 2023, page 621, states in part, .Verify the practitioner's order for the oxygen therapy, because oxygen is considered a medication or therapy and should be prescribed . Review of a facility policy titled, Oxygen: Nasal Cannula [a device used to deliver oxygen through a tube in the nose] dated 8/7/2023, states in part, .Verify order .Humidifying device [a bottle that infuses the normal flow of oxygen with water droplets to reduce the sensations of dryness in the upper airway] if liter flow greater than or equal to four liters . 1. Record review revealed Resident ID #24 was admitted to the facility in September of 2024 with a diagnosis including, but not limited to, emphysema (a chronic lung disease that causes progressive damage to the air sacs in the lungs). Record review revealed a physician's order dated 2/15/2025 to administer oxygen at 5-7 liters (L) via nasal cannula, as tolerated. Surveyor observations revealed the resident was receiving 8 liters of oxygen instead of 5-7 L, as ordered, on the following dates and times: - 3/4/2025 at 9:26 AM, 12:45 PM, and 3:30 PM. - 3/5/2025 at 10:45 AM. Additional surveyor observations of the resident revealed the oxygen tubing was not connected to the humidifier bottle on the concentrator (a medical device that delivers oxygen-enriched air to people who have breathing difficulties) on the following dates and times: - 3/4/2025 at 9:26 AM, 12:45 PM, and 3:30 PM - 3/5/2025 at 10:45 AM During a surveyor interview on 3/4/2025 at 3:30 PM with Licensed Practical Nurse, Staff E, she was unable to provide evidence that the resident was receiving 5-7 L of oxygen, as ordered. Additionally, she was unable to provide evidence that the humidifier was connected to the concentrator. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 3/5/2025 at 10:26 AM, with Resident ID #24, s/he revealed s/he does not adjust the liter flow of the oxygen and indicated that the nurses adjust the liter flow of oxygen s/he receives. Additionally, the resident revealed s/he was aware the humidifier was not connected and that s/he does get nosebleeds. Additional surveyor observation of Resident ID #24 immediately following the above-mentioned interview, revealed a blood-tinged napkin that was in a cup on his/her bedside table. During a surveyor interview on 3/5/2025 at 11:25 AM with the Director of Nursing Services, she indicated that she would expect Resident ID #24 to receive the liters of oxygen, as ordered. 2. Record review revealed Resident ID #154 was admitted to the facility in February of 2025 with a diagnosis including, but not limited to, chronic obstructive pulmonary disease (a lung disease that causes restricted airflow and breathing problems). During surveyor observations on the following dates and times, Resident ID #154 was observed receiving 3 (L) of oxygen via a nasal cannula: - 3/3/2025 at 10:31 AM - 3/4/2025 at 9:35 AM, 9:58 AM, 11:54 AM, and 12:20 PM. Record review failed to reveal evidence of a physician's order for oxygen as indicated in the facility's policy. During a surveyor interview on 3/4/2025 at 12:25 PM with Registered Nurse, Staff C, she acknowledged that the resident was receiving 3 L of oxygen. Staff C further acknowledged that the resident did not have a physician's order for the oxygen s/he was receiving. During a surveyor interview on 3/4/2025 at 1:34 PM with the Director of Nursing Services, she indicated that she would expect the staff to have obtained a physician's order for the oxygen being administered to Resident ID #154. 45263

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41729 Based on surveyor observation, record review, resident and staff interviews, it has been determined that the facility failed to ensure that residents who require dialysis (a life-sustaining treatment that is used to remove waste products and excess fluid from the blood when a person's kidneys are no longer functioning) receive such services, consistent with professional standards of practice for 1 of 1 resident reviewed for fluid restriction and on a renal diet (a dietary plan specifically designed for people with kidney disease), Resident ID #77. Findings are as follows: Review of a facility diet manual titled, Diet and Nutritional Care Manual: Renal Dialysis Diet states in part, . Foods to limit/avoid .oranges/orange juice . Review of the facility's policy titled, Nutrition/Hydration Care and Services dated 2/1/2023, states in part, . When a physician/APP [Advanced Practice Practitioner]orders a fluid restriction due to specific clinical condition: Orders must include volume of fluid permitted during a 24-hour period . Record review revealed the resident was admitted to the facility in January 2025 with diagnoses including, but not limited to, end stage renal disease (a severe medical condition where the kidneys have permanently lost their ability to function properly) and dependence on renal dialysis. Review of an Admission Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status Score of 15 out of 15, indicating intact cognitive function. Review of a physician's order dated 1/30/2025 revealed to monitor daily fluid restriction with a total of 1000 milliliter (ML) a day. Review of a physician's order dated 2/1/2025 revealed the resident receives outpatient dialysis three times a week on Tuesday, Thursday, and Saturday. Record review failed to reveal evidence that the resident's fluid intake was monitored and documented over a 24-hour period, as indicated in the facility's policy. During a surveyor interview on 3/6/2025 at 9:14 AM with Registered Nurse, Staff C, she acknowledged that the resident is on a 1000 ML/day fluid restriction. Staff C indicated that she only documents fluids that she provides to the resident and does not keep track of all fluids the resident receives. Additionally, Staff C was unable to provide evidence why the resident was served orange juice or who had given him/her the orange juice. During a surveyor observation on 3/6/2025 at 9:19 AM, the resident was observed with a coffee mug (holds 240 ML of fluids) that had approximately 30 ML of orange juice in it. During a surveyor interview on 3/6/2025 at approximately 9:20 AM with the resident, s/he acknowledged that a staff member had served him/her orange juice and s/he had drank it. The resident further acknowledged that s/he should not be drinking orange juice because of his/her renal diet. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 3/6/2025 at 9:32 AM with the Director of Nursing Services (DNS), she indicated that she would expect the staff to follow all physician's orders relating to the resident's diet and fluid restriction. Additionally, the DNS was unable to provide evidence that the resident's total fluid intake was being monitored and documented, per the facilities policy. During a surveyor interview on 3/6/2025 at 10:06 AM with the Registered Dietitian (RD), she acknowledged that the resident is on a renal diet and should not have been served orange juice. Additionally, the RD indicated that the resident's diet slip did not indicate the resident should not be receiving orange juice.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 41729 Based on record review and staff interview, it has been determined that the facility failed to ensure that the resident's drug regimen is free from unnecessary drugs for 1 of 1 resident reviewed for a medication with parameters, Resident ID #77. Findings are as follows: Record review revealed the resident was admitted to the facility in January 2025 with diagnoses including, but not limited to, end stage renal disease (a severe medical condition where the kidneys have permanently lost their ability to function properly) and dependence on renal dialysis (a life-sustaining treatment that is used to remove waste products and excess fluid from the blood when a person's kidneys are no longer functioning). Review of a physician's order dated 1/31/2025 revealed Isosorbide Mononitrate 60 milligram, two times a day (morning and evening) for high blood pressure with parameters to hold the medication if the systolic blood pressure (SBP; top number in a blood pressure reading) is less than 120. Review of the February and March 2025 Medication Administration Records (MAR) revealed that the resident was administered the Isosorbide Mononitrate when his/her SBP indicated it should be held based on the parameters on the following dates and times: - 2/1/2025- morning BP: 97/57, 105/68, evening BP: 107/66 - 2/3/2025- morning BP: 110/47 - 2/5/2025- evening BP: 108/51 - 2/6/2025- morning BP: 112/61 - 2/7/2025- morning BP: 106/50 - 2/8/2025- evening BP: 111/62 - 2/10/2025-morning BP: 111/58 - 2/11/2025-morning BP: 113/66 and evening BP 114/69 - 2/12/2025-evening BP: 99/52 - 2/14/2025- evening BP:112/56 - 2/17/2025- morning BP: 102/60 - 2/19/2025-evening BP: 112/62 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 2/22/2025- morning BP: 112/65 - 2/23/2025- morning BP: 114/60 - 2/24/2025- morning BP: 117/66 - 2/25/2025- morning BP: 109/60 - 2/27/2025- morning BP:108/61 - 2/28/2025- evening BP: 100/62 - 3/3/2025- morning BP: 97/56 and evening BP: 102/65 - 3/4/2025-evening blood pressure (BP): 98/69 During a surveyor interview on 3/5/2025 at 9:56 AM with the Nurse Practitioner, she indicated that she would expect the resident's Isosorbide Mononitrate to have been held on the above-mentioned dates and times when his/her SBP was lower than 120, as ordered. During a surveyor interview on 3/5/2025 at 11:54 AM with the Director of Nursing Services, she was unable to provide evidence that the staff followed the physician's order for administering the Isosorbide Mononitrate.

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F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41729

47279

Based on surveyor observation, resident, and staff interview, it has been determined that the facility failed to store and label drugs and biological's in accordance with currently accepted professional standards for 2 of 4 medication carts observed, and 1 of 1 resident's room observed with medication at the bedside, Resident ID #99.

Findings are as follows:

Review of a facility policy titled, Medication Administration dated 1/2025, states in part, .Medications are to be administered at the time they are prepared .

1) Record review revealed Resident ID #99 was admitted to the facility in February of 2025 with diagnoses including, but not limited to, displaced intertrochanteric fracture of the left femur (a break in the upper thigh bone) and pain in the left hip.

Record review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status score of 15 out of 15, indicating intact cognition.

Review of a physician's order dated 2/18/2025 revealed to apply a Lidoderm patch 5% to the left hip in the morning for pain.

During surveyor observations on the following dates and times, an opened package of a Lidoderm patch was observed on the resident's nightstand:

- 3/3/2024 at 11:15 AM

- 3/4/2025 at 9:45 AM

- 3/5/2025 at 8:59 AM

During a surveyor interview on 3/3/2025 at 11:16 AM with the resident, s/he indicated that the Lidoderm patch was left on the nightstand by a staff member a few days prior.

During a surveyor observation on 3/5/2025 at 9:00 AM in the presence of Registered Nurse (RN), Staff F, she acknowledged that the opened package of a Lidoderm patch was observed on the resident's nightstand. Staff F indicated that she was unaware who had placed the patch on the nightstand.

During a surveyor interview on 3/5/2025 at 11:49 AM with the Director of Nursing Services (DNS), she was unable to provide evidence as to why the opened Lidoderm patch was left on the resident's nightstand. Additionally, the DNS indicated that it is not the facility's practice to leave medications at a resident's bedside.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2a) During a surveyor observation on 3/4/2025 at 1:42 PM of the first floor, East Unit medication cart, with RN, Staff D during the medication administration task, she removed a clear medication cup without any labels containing 2 orange tablets from the medication cart to administer to a resident. During a surveyor interview with Staff D immediately following the above-mentioned observation, she revealed that she pre-poured the medication to administer to a resident. She acknowledged that the medication cup was unlabeled and revealed that it is not her usual practice to pre-pour medication for a resident. 2b) During a surveyor observation on 3/5/2025 at approximately 9:45 AM of the first floor, South Unit medication cart, in the presence of Staff D, revealed a clear medication cup with the label 23 written in marker containing 1 white tablet. During a surveyor interview with Staff D immediately following the above-mentioned observation, she revealed that the medication cup containing the white tablet was in the medication cart when she assumed care of the unit from the nurse prior, and was unaware of what the medication was or who it was for. She further revealed that the medication should be discarded. During a surveyor interview on 3/4/2025 at 3:56 PM with the DNS, she revealed that she would expect staff not to pre-pour medication and store it in a medication cart. Additionally, she would expect staff to administer medication to a resident at the time it was prepared.

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NAME OF PROVIDER OR SUPPLIER Greenwood Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 47279 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to prepare food and drink in a form designed to meet individual needs for 1 of 1 resident observed during the medication administration task that requires honey thickened liquids (liquid consistency that should flow like honey pouring off a spoon), Resident ID #69. Findings are as follows: Record review revealed the resident was admitted to the facility in August of 2024 with diagnoses including, but not limited to, dysphagia (difficulty swallowing) and aspiration (when something that is supposed to enter your stomach accidentally enters your airway) of fluid. During a surveyor observation on 3/5/2025 at approximately 9:30 AM, Registered Nurse, Staff D, was observed administering liquid Ativan (medication for anxiety) orally via a syringe to Resident ID #69. Staff D then provided the resident with a cup of clear, thin liquid which the resident took small sips of through a straw and began to cough after consuming it. Staff D then prepared liquid morphine (medication for pain relief) and administered it to the resident orally via a syringe. Staff D, again, provided the resident with cup of clear, thin liquid in which the resident took several sips of through a straw and began to cough. Record review in the presence of Staff D, revealed that the resident is prescribed a modified diet due to dysphagia and requires honey thickened liquids. During a surveyor interview immediately following the above observation on 3/5/2025 with Staff D, she revealed that she was unsure of the resident's prescribed diet and had to reference his/her record. Additionally, she acknowledged that the resident requires honey thickened liquids and revealed that she had administered the resident water that was not a honey thick consistency, as prescribed. Record review of the resident's care plan revealed a focus area dated 9/25/2024 indicating that s/he is at nutritional risk related to difficulty swallowing with an intervention that includes to provide him/her with honey thickened liquids, as ordered. Additionally, it revealed that s/he requires honey thickened liquids for all liquids. Record review of a progress note dated 3/5/2025 at 10:13 AM authored by Staff D, revealed that the resident experienced a change in condition with his/her respiratory status and was coughing following the administration of thin liquids with his/her medication. During surveyor interviews on 3/5/2025 at 12:53 PM and 2:28 PM with the Director of Nursing Services, she revealed that she would expect that staff would provide the resident with honey thickened liquids, as ordered, and to check his/her diet order prior to administering food or drinks. 41729

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41729 45263 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, relative to the main kitchen and the main dining room. Findings are as follows: 1. The Rhode Island Food Code 2018 Edition 4-601.11 states in part, .Nonfood contact surfaces shall be kept free of an accumulation of dirt, dust, food residue, and other debris . During a surveyor observations on 3/3/2025 at 8:25 AM of the main kitchen during the initial tour revealed the following: - Grease accumulation along the inner rim of the hood over the stove - Ice machine dispenser cover was held with black masking tape, which is not a cleanable surface area - Utility cart with a wooden handle; a porous surface not able to be washed and sanitized - 10 food meal delivery carts with grease and grime accumulation along the lower edges and wheels 2. The Rhode Island Food Code 2018 Edition 3.501.16 states in part, .Time/Temperature Control for Safety Food, Hot and Cold Holding .shall be maintained at .5 degrees C [Celsius] (41 degrees Fahrenheit [F]) or less . Record review of the facility menu for the lunch meal on 3/6/2025 revealed the following: - Italian Sub Sandwich - Creamy Coleslaw - Snickerdoodle Cookies During a surveyor observation on 3/6/2025 at approximately 11:45 AM of the lunch meal being served from the main kitchen revealed the following: - Cold holding temperature reading of the Italian Sub Sandwich 48 degree F. - Cold holding temperature reading of Coleslaw was 45 degrees F. -Cold holding temperature of the Ground textured Italian Sub Sandwich was 45 degrees F. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a surveyor interview immediately following the above-mentioned observations, the Food Service Director (FDS) acknowledged the cold holding temperatures of the above-mentioned food items were not within the acceptable parameters. 3. The Rhode Island Food Code 2018 Edition 4-601.11 states in part, .food contact surfaces shall be cleaned to sight . During a surveyor observation on 3/3/2025 at approximately 8:25 AM of the ice machine, revealed the lower portion of the ice chute [dispenser] had an accumulation of black particles. 4. The [NAME] Food Code 2018 Edition 3-302-12 Food Storage Containers, Identified with Common Name of Food states in part, .Except for containers holding Food that can be readily and unmistakably recognized . working containers holding Food or Food ingredients that are removed from their original packages for use . shall be identified with the common name of the Food . During a surveyor observation on 3/3/2025 at approximately 8:25 AM of the walk-in refrigerator in the main kitchen revealed the following: - 1-quart clear container with a brown colored liquid substance that did not have a food identifier - 1-quart clear container with a tan colored product that did not have a food identifier - 1-quart clear container with slices of a white colored product that did not have a food identifier 5. Record review of the manufacturer's label for a Vital Cuisine Mighty Shake states in part, .use within 14 days of thawing . During a surveyor observation on 3/3/2025 at 8:25 AM of the walk-in refrigerator in the main kitchen revealed the following: - sixty 4 ounce (oz) of Vital Cuisine Mighty Shakes without a use by date to identify when the product was thawed. 6. Record review of a facility policy titled, Labeling and Dating states in part the following: .Ready to eat foods will be labeled and dated with a prepped date (Day 1) and a use by date (Day 7) During a surveyor observation on 3/4/2025 at 8:25 AM of the walk-in refrigerator in the main kitchen revealed the following: - 1-quart container of egg salad with a date of 2/29 (28 days in February) and a use by date of 3/2/2025. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a surveyor interview on 3/6/2025 at 1:15 PM with the FSD, she acknowledged the rim of the hood over the stove, the ice chute and the lower rims of the food delivery carts need cleaning. She further acknowledged the above-mentioned food items stored in the walk-in refrigerator were beyond their used by dates and did not have labeled identifiers. Additionally, the FSD acknowledged that the Vital Cuisine Mighty Shakes were not labeled with a used by date, as required.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 43987 41729 47279 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections relative to Enhanced Barrier Precautions (EBP; involves using a gown and gloves during high-contact resident care activities) 1 of 1 resident reviewed with a suprapubic tube (SPT; a tube that drains urine from your bladder through a small incision in your abdomen), Resident ID #37 and for 1 of 1 resident observed for medication administration via a peripherally inserted central catheter (PICC; a long, thin tube inserted through a vein in your arm that extends to your heart), Resident ID #51. Findings are as follows: Review of a facility policy titled, .Enhanced Barrier Precautions last reviewed 12/16/2024 states in part, . Enhanced Barrier Precautions (EBP) .employs targeted personal protective equipment (PPE) use during high contact patient/resident .activities .Implementation of EBP .Has a .indwelling medical device .Yes . 1. Review of a facility policy titled, Catheter: Indwelling Urinary-Care last reviewed on 2/1/2023 states in part, Perform catheter care twice a day and PRN [as needed] .Gather equipment (PPE), as indicated .Put on gloves and other PPE as indicated .Secure catheter tubing to keep the drainage bag below the level of the patient's bladder and off the floor . Record review revealed Resident ID #37 was readmitted to the facility in November of 2019 with a diagnosis including, but not limited to, neuromuscular dysfunction of the bladder. a) Record review revealed that the resident has an SPT. Additionally, s/he is on EBP due to having an SPT. Review of the EBP sign posted near the resident's door states in part, .Enhanced Barrier Precautions . Attention: Caregivers, Staff .Wear Gown and Gloves prior to these activities .Providing hygiene .Changing briefs or assisting with toileting .Device care or use of a device that is .urinary catheters . During surveyor observations on the following dates and times the resident's SPT collection bag was noted to be resting on the floor next to the resident's bed: -3/4/2025 at 9:05 AM, 10:28 AM, 12:04 PM, and 12:32 PM -3/5/2025 at 10:07 AM and 10:15 AM (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 3/5/2025 immediately after the above observation at 10:15 AM with Registered Nurse (RN), Staff A, she acknowledged that the resident's SPT collection bag was resting on the floor and indicated that it should not be. b) During a surveyor observation on 3/3/2025 at 12:39 PM, Nursing Assistant, Staff G, was observed providing hygiene care for the resident after assisting him/her with toileting without wearing a gown. During a surveyor interview immediately following the above observation, Staff G acknowledged that she did not wear a gown while assisting the resident with toileting and providing hygiene care. Additionally, she revealed that she was aware that she required a gown. During a surveyor interview on 3/5/2025 at 2:14 PM with the Director of Nursing Services (DNS), she revealed that she would have expected staff to wear a gown while assisting a resident on EBP with toileting and providing hygiene. Additionally, the DNS revealed that she would have expected the resident's SPT collection bag to be off of the floor. 2. Record review revealed Resident ID #51 was admitted to the facility in June of 2014 with a diagnosis including, but not limited to, osteomyelitis (an infection in a bone). Record review revealed that the resident has a PICC line. Review of the resident's care plan revealed that s/he is on EBP due to his/her PICC line with an intervention dated 1/23/2025 that includes to use EBP with the use of a device such as a central line. Review of a physician's order dated 1/16/2025 revealed to administer Ertapenem (an antibiotic) 1 gram, intravenously (IV), every 24 hours for osteomyelitis. Review of the EBP sign posted near the resident's door states in part, .Enhanced Barrier Precautions . Attention: Caregivers, Staff .Wear Gown and Gloves prior to these activities .Device care or use of a device . central lines . During a surveyor observation on 3/4/2025 at 1:29 PM during the medication administration task revealed Staff A, access the resident's PICC line and began infusing his/her IV antibiotic without wearing a gown. During a surveyor interview immediately following the above observation with Staff A, she acknowledged that the resident is on EBP and that the use of a gown is required when accessing his/her PICC line. She further acknowledged that she did not wear a gown, and should have. During a surveyor interview on 3/4/2025 at 3:56 PM with the DNS, she revealed that she would expect the nurse to wear a gown when administering IV antibiotics via a PICC line for a resident on EBP.

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F 0921

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47279

Based on surveyor observation, resident and staff interviews, it has been determined that the facility failed to maintain a safe, functional, and comfortable environment for residents, staff, and the public relative to resident rooms and furnishings in disrepair on 2 of 6 units observed, affecting Resident ID #s 14, 70, 73, and 79.

Findings are as follows:

1a) Record review revealed Resident ID #14 was admitted to the facility in May of 2021 with a diagnosis including, but not limited to, heart failure. Additionally, s/he resides on the second floor, South Unit.

Review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 15 out of 15, indicating intact cognition.

Review of the resident's care plan revealed that s/he prefers to sleep in his/her recliner.

During a surveyor observation on 3/3/2024 at 10:37 AM of the resident, s/he was seated in his/her recliner in his/her room. Additionally, the cloth upholstery to the right arm of the recliner was torn exposing the foam cushioning beneath.

During a surveyor interview immediately following the above observation with the resident, s/he revealed that his/her recliner has been in the condition as described above for approximately a few weeks and that the facility is aware. S/he further revealed that the ripped upholstery bothers him/her. Additionally, the resident revealed that the recliner was provided to him/her by the facility.

Additional surveyor observations on the following dates and times revealed the resident's recliner in the same condition as described above:

-3/4/2025 at 12:28 PM

-3/5/2025 at 10:15 AM

-3/6/2025 at 9:55 AM

During a surveyor interview immediately following the above observation on 3/6/2025 with Maintenance Assistant, Staff H, he acknowledged that the recliner was in disrepair and revealed that he was unaware of its condition. Additionally, he acknowledged he could provide the resident with another recliner if one is available or attempt to repair the current one.

1b) Record review revealed Resident ID #79 was admitted to the facility in February of 2024 with a diagnosis including, but not limited to, anxiety disorder. Additionally, s/he resides on the second floor, South Unit.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 3/3/2025 at 10:27 AM with the resident, s/he revealed that his/her room has a draft because the left side of the window is missing weather stripping, as a result, the room is colder when it is windy. S/he further revealed that it is bothersome to him/her. Additionally, the resident revealed that the window has been in that condition since s/he has been at the facility, and that the facility is aware. Additional surveyor observations on the following dates and times revealed the resident's window in the same condition as described above: -3/4/2025 at 3:31 PM -3/5/2025 at approximately 10:15 AM -3/6/2025 at 10:00 AM During a surveyor interview immediately following the above observation on 3/6/2025 with Staff H, he revealed that the window could use weather stripping. Additionally, he revealed that he was unaware of the condition of the window. 1c) Record review revealed Resident ID #73 was admitted to the facility in August of 2024 with a diagnosis including, but not limited to, encounter for palliative care (specialized medical care that provides comfort and relief for individuals with serious or progressive illnesses). Additionally, s/he resides on the second floor, East Unit. Surveyor observations on the following dates and times revealed a large, unpainted area of the wall measuring approximately 4 feet by 4 feet next to the resident's bed: -3/3/2025 at 11:00 AM -3/4/2025 at 12:26 PM -3/5/2025 at approximately 10:13 AM -3/6/2025 at 10:03 AM During a surveyor interview on 3/6/2025 at 9:46 AM with the resident's Hospice Aide, Staff I, she revealed that the resident's wall has been unpainted for several months and the resident expresses to her that it bothers him/her. She further revealed that the resident talks about it all the time. During a surveyor interview following the above observation on 3/6/2025 at 10:03 AM with Staff H, he acknowledged the large, unpainted area of the wall area by the resident's bedside. He revealed that approximately 2-3 months prior, he had repaired the damaged wall in the residents room but had not painted it. 1d) Record review revealed Resident ID #70 was admitted to the facility in January of 2024 with a diagnosis including, but not limited to, Parkinson's disease. Additionally, s/he resides on the second floor, East Unit. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor observations on the following dates and times revealed a large, unpainted area of the wall with several gouges measuring approximately 4 feet by 5 feet behind the resident's bed: -3/3/2025 at 11:10 AM -3/4/2025 at 12:24 PM -3/5/2025 at 10:14 AM -3/6/2025 at 10:04 AM During a surveyor interview following the above observation on 3/6/2025 with Staff H, he acknowledged the large, unpainted area and gouges in the wall behind the resident's bed. He revealed that he was unaware that the resident's wall was in disrepair and indicated that nursing staff should utilize the facility's system called Tels to communicate with maintenance, which is something he checks daily. During a surveyor interview on 3/6/2025 at approximately 12:00 PM with the Administrator, he was unable to provide evidence that the facility maintained a safe, functional, and comfortable environment for the above-mentioned residents. During a surveyor interview on 3/6/2025 at 12:30 PM with the Maintenance Director, he revealed that he would expect staff to utilize the Tels system to notify the Maintenance Department of anything that requires their attention so they can address it. Additionally, he revealed that he would have expected Staff H to have repainted Resident ID #73's wall within a week of when it had been repaired. 41729