STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415012	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcliffe Manor	49 Old Pocasset Road Johnston, RI 02919

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on surveyor observation, staff interview, and clinical record review, the facility failed to ensure medications were stored and labeled in accordance with currently accepted professional standards of practice for 2 of 3 Certified Medication Technician (CMT) carts reviewed and for 1 of 1 medication room.Findings are as follows:1a. During a surveyor observation on 6/8/2026 at approximately 8:30 AM in the presence of CMT, Staff C, the following was observed:-One opened bottle of Pro-Stat liquid protein supplement, open and undated. Review of the manufacturer's instructions indicated the bottle must be labeled and dated upon opening and discarded 3 months after opening.-One Breo Ellipta inhaler: The inhaler was open and undated. Review of the manufacturer's instructions indicated the device must be discarded 6 weeks after the protective foil tray is opened.-One box of Artificial Tears: The bottle was open, undated, and failed to have a resident-specific label identifying the resident for whom it was prescribed.-One Trelegy Ellipta inhaler: The inhaler was open and undated. Review of the manufacturer's instructions indicated the device must be discarded 6 weeks after opening.During a surveyor interview at the time of the above observation, Staff C acknowledged the medications were open, actively being used, and failed to indicate the date they were opened in order to track expiration. Additionally, she acknowledged that the eye drops failed to have a resident specific label identifying the resident for whom it was prescribed.1b. During a surveyor observation on 6/8/2026 at approximately 9:00 AM in the presence of CMT, Staff D, the following was observed:-One Qvar Redihaler: the device was labeled as opened on 3/18/2026. Record review revealed this medication was discontinued on 3/20/2026; however, it remained in storage in the cart available for administration.-One box of Artificial Tears: The bottle was open and undated.-Three boxes of Artificial Tears: The bottles were stored in the cart but failed to have a resident-specific label identifying the resident(s) for whom they were prescribed.During a surveyor interview at the time of the observations, Staff D acknowledged the findings, confirmed the presence of the discontinued medication and the multiple undated/labeled items in the cart.2. During a surveyor observation on 6/8/2026 at approximately 10:15 AM, an inspection of the 3rd Floor Medication Room was conducted in the presence of Licensed Practical Nurse, Staff E, and the following was observed:-The medication room refrigerator was observed to have a heavy accumulation of ice buildup inside of the freezer, which extended down into the refrigerator compartment where resident medications were stored. This ice buildup was actively melting and dripping water into the main refrigerator. During a surveyor interview at the time of the above observation, Staff E acknowledged the heavy ice accumulation and the water dripping into the refrigerator where medication was being stored. During an interview on 6/9/2026 at approximately 8:56 AM, with the Director of Nursing Services (DNS), she acknowledged that medications stored in CMT carts must be labeled with a resident-specific identifier to ensure administration to the correct resident. She also acknowledged that discontinued medications should be removed from the medication carts. The DNS stated that the refrigerator was cleaned and the ice was removed after the surveyor identified the concern. Additionally, she confirmed that pharmacy instructions require artificial tears to be labeled upon opening, however, she was unable to provide (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415012	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcliffe Manor	49 Old Pocasset Road Johnston, RI 02919

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	evidence that medications with shortened expiration dates after opening were labeled in accordance with manufacturer guidelines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415012	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcliffe Manor	49 Old Pocasset Road Johnston, RI 02919

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on surveyor observation and staff interview, the facility failed to ensure that appropriate infection control practices were maintained to prevent the potential spread of communicable diseases and cross-contamination. This deficient practice was identified during the observations made during the medication administration task of blood glucose monitoring and insulin administration for 2 of 3 residents reviewed, Resident ID #s 133 and 136. Furthermore, the facility failed to implement Enhanced Barrier Precautions (EBP) for 1 of 2 residents reviewed with a non-pressure wound, Resident ID #78.Findings are as follows:1. According to Centers for Disease Control and Prevention (CDC) infection control guidelines titled, HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) revealed that all PPE must be completely removed and discarded before exiting the resident's room.During a surveyor observation on 6/8/2026 at approximately 11:30 AM, Licensed Practical Nurse, Staff B, entered Resident ID #136's room to obtain a blood sugar reading via a fingerstick (the pricking of a finger in order to obtain a small sample of blood). Further observation revealed that Resident ID #136 room, had signage posted at his/her doorway indicating the use of Droplet Precautions, due to a respiratory infection.Upon completing the fingerstick, Staff B exited the resident's room into the unit's hallway while still wearing the contaminated isolation gown and surgical mask that was worn inside the droplet precaution room. Staff B went directly to her medication cart, obtained Resident ID #136's insulin from the medication cart, and re-entered the resident's room.During a surveyor interview immediately following the above observation, Staff B acknowledged that the resident was on droplet precautions due to an active respiratory infection. She acknowledged that after obtaining the resident's the blood sugar fingerstick, she exited the isolation room and went into the unit's hallway to the medication cart and retrieved the resident's insulin while still wearing the contaminated isolation gown and surgical mask that had been worn inside the droplet precaution room. Additionally, Staff B acknowledged that she should have removed the contaminated gown and mask prior to exiting the resident's room.2. Review of an undated facility policy titled Blood Sampling - Capillary (Finger Sticks), revealed to .ensure blood glucose meters [glucometer] intended for reuse are cleaned and disinfected between resident use.Review of the manufacturer's usage instructions for Clorox Helathcare Bleach Germicidal Wipes, revealed, .Wipe the surface until completely wet. Wait for the contact time (3 minutes for C. diff, fungi, TB and select viruses; 30 second for bacteria; 1 minute for most viruses) .Discard the wipe.During a surveyor observation on 6/8/2026 at approximately 12:06 PM, Registered Nurse (RN), Staff F, was observed performing a fingerstick blood glucose test on Resident ID #133. Prior to the procedure, Staff F utilized a manufacturer-approved bleach wipe to clean the glucometer. Staff F failed to allow the disinfectant to remain wet on the surface of the device for the required manufacturer-specified contact time (dwell time) of 3 minutes. Immediately after applying the bleach wipe, Staff F took a dry paper towel and wiped the liquid disinfectant off of the glucometer, rendering the disinfection process ineffective. Additionally, as the glucometer became wet internally, it displayed an error code after a test strip was inserted. Staff F repeated this process two additional times because of the error code reading. During a surveyor interview immediately following the above observation, Staff F acknowledged that he utilized a manufacturer-approved bleach wipe to clean the glucometer but failed to allow the chemical disinfectant to remain wet on the device's surface for the required manufacturer-specified contact time of 3 minutes. He acknowledged that the device should have remained wet for the full dwell time to achieve proper disinfection.During a surveyor interview on 6/9/2026 at 8:49 AM, the Director of Nursing Services (DNS) revealed it is her expectation that all staff follow manufacturer guidelines for equipment disinfection. Additionally, she acknowledged that staff should not exit an isolation room wearing contaminated PPE.3. According to the CDC, EBP is required for all residents with chronic wounds during high-contact activities, regardless of MDRO (multi-drug resistant organisms) status. The CDC defines a chronic wound as any skin injury requiring specialized treatment beyond a simple (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415012	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcliffe Manor	49 Old Pocasset Road Johnston, RI 02919

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	adhesive bandage. Staff must wear gowns and gloves during the high contact activities (such as dressing, bathing, transfers, and wound care) to prevent pathogen transmission.Record review revealed Resident ID #78 was readmitted to the facility in October of 2024 with a diagnosis including, but not limited to, diabetes. S/he subsequently developed a left foot/heel skin tear on 4/6/2026. The wound healing was stalled, requiring a referral to an external wound clinic initiated on 6/5/2026.Review of a physician's order originally dated 5/27/2026, and reordered continuously every 7 days, revealed the wound required a specialized, multi-step treatment, rather than a simple bandage. The active order dated 6/3/2026 was to cleanse the left foot/heel skin tear with Normal Saline (NS, a sterile salt water solution used to flush and clean debris from wounds), apply Santyl ointment 250 units/gram (a specialized enzymatic debriding agent used to actively remove dead, non-viable tissue from the wound bed), followed by Maxsorb (a highly absorbent alginate dressing designed to manage heavy wound drainage and maintain a moist environment), then cover the wound with a foam dressing (a thick protective barrier that cushions the area and locks in moisture) daily.Review of a nursing progress note dated 6/10/2026, authored by RN Supervisor, Staff G, revealed an alteration in skin assessment detailing that the resident's left foot/heel skin tear continued with scant serosanguineous (a pink wound fluid) drainage noted with no odor. The wound bed was noted to be pink with white and dark spots present, with no swelling, no warmth, and no signs or symptoms of infection. The resident was scheduled for an external wound clinic appointment for the following week and was to continue with the same wound care order listed above.Surveyor observations from 6/8/2026 through 6/11/2026 revealed, EBP was not implement, as there was no isolation signage posted nor were there any PPE carts by the resident's doorway.During a surveyor interview on 6/11/2026 at 7:42 AM with RN, Staff H, she acknowledged that Resident #78 was not placed on EBP, confirming that no orders for the resident to be placed on EBP and PPE was not being utilized by the nursing staff during care.During a surveyor interview on 6/11/2026 at 9:49 AM, Staff G stated she completed the wound assessment on 6/10/2026 and described the wound as being the size of a half-dollar with a pink wound bed and scattered small dark/brown areas of tissue which is opened and draining. The wound was a skin tear that originally developed in April 2026. She revealed that the skin flap has been open and has remained stagnant and unchanged since April. She revealed that a wound clinic referral was made due to lack of progression, resident comorbidities, and vascular issues. When asked why Resident #78 was not on EBP, Staff G acknowledged the resident's history of diabetes and confirmed that the treatment required a complex dressing rather than a simple bandage; however, she stated the resident was not placed on EBP because it was a skin tear and was still considered fairly new. When asked to define a chronic wound, she stated it was a wound that is being maintained for a long period of time and noted there had been no progression since the skin tear was first identified two months prior. She stated that the Interdisciplinary Team (IDT) determines precautions, and that the IDT reviewed the resident and decided to order a wound clinic consult due to the lack of progression but did not initiate EBP.During surveyor interviews on 6/11/2026 at 9:26 AM and 11:17 AM with the DNS, she acknowledged that EBP was not initiated for Resident ID #78 as it was not a chronic wound. Additionally, when questioned on facility protocol and federal guidelines, the DNS was unable to define what constitutes a wound as chronic.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415012	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcliffe Manor	49 Old Pocasset Road Johnston, RI 02919

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 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and staff interview, the facility failed to send a copy of the written notices for all resident discharges to a representative of the State Office of the Long-Term Care (LTC) Ombudsman, at the same time it was issued to the residents and their representative(s).Findings are as follows:Review of a document titled, Highlights of Federal Nursing Facility Requirements and Guidance Regarding Transfer and Discharge Notices, authored by The National Long-Term Care Ombudsman Resource Center, last revised on 7/23/2025, states in part, .Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another facility or other location in the community, when return to the original facility is not expected.The facility must not transfer or discharge the resident from the facility unless: The resident's needs cannot be met in the facility; The resident's health has improved and the resident no longer needs the services provided by the facility; The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; The health of individuals in the facility would otherwise be endangered; The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility; or The facility ceases to operate.Further review of the Highlights of Federal Nursing Facility Requirements and Guidance Regarding Transfer and Discharge Notices, states in part, .Before a facility transfers or discharges a resident, the facility must .send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.Review of the facility's discharges from March 1 through May 31, 2026, failed to reveal evidence that a notification to the representative of the State LTC Ombudsman was provided for residents who were discharged to another facility or other location in the community, when the return to the original facility was not expected, or for a resident that left the facility against medical advice.During a surveyor interview on 6/9/2026 at 12:56 PM, with Social Services Staff A, she revealed that the facility does not provide notification to a representative of the State LTC Ombudsman when a resident is discharged , indicating they only provide notification of residents who have been transferred to the hospital.During a surveyor interview on 6/11/2026 at 9:09 AM, the Director of Nursing Services stated that the facility only issues notifications to the State LTC Ombudsman when a resident is transferred to the hospital or when a resident is discharged following a formal 30-day notice. Additionally, she revealed that the facility does not notify the State LTC Ombudsman of any other type of discharges.