STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415014	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Barker Nursing Center	54 Barker Avenue Warren, RI 02885

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, and staff interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections relative to following proper infection control practices consistent with professional standards of practice for 1 of 1 resident observed with a disconnected indwelling catheter (a flexible tube inserted into your bladder that drains urine into a collection bag), who requires enhanced barrier precautions (EBP, personal protective equipment worn in addition to standard precautions that requires a gown and gloves for all residents with infection or colonization of a multidrug resistant organism [MDRO] and for residents with wounds or indwelling medical devices), Resident ID #8. Additionally, the facility failed to update their pneumonia vaccine policy to align with current guidelines as recommended by the Advisory Council on Immunization Practices (ACIP).Findings are as follows:1. Review of an undated facility policy titled, Policy: Foley Urinary Drainage Bag Replacement and Care states in part, Connection Care.always clean the connection point between the catheter and the bag using alcohol wipes.Record review revealed that Resident ID #8 was admitted to the facility in July of 2024 with a diagnosis including, but not limited to, urinary retention.Review of the resident's care plan revealed s/he is at risk for a urinary tract infection related to frequently removing his/her indwelling catheter. Additionally, s/he requires EBP.During surveyor observations from 4/27/2026 through 4/30/2026 of the resident's room, revealed signage posted outside his/her room indicating that s/he is on EBP, and to wear gloves and a gown for any device care or use which includes a urinary catheter.During a surveyor observation on 4/27/2026 at approximately 10:30 AM of the resident's room, revealed the resident's catheter drainage bag was disconnected from the resident, with the tubing draped up over the footboard of the bed, and the tip of the drainage bag tubing that should be inserted into the catheter was noted to be touching the footboard with urine dripping onto the floor. Additionally, the surveyor immediately notified Nursing Assistant, Staff A, entered the resident's room to find the resident in the bathroom, with the indwelling catheter still intact, and assisted him/her back to his/her bed. Further, Staff A reconnected the resident's catheter drainage bag to the resident's catheter without first cleaning the drainage bag nor indwelling catheter with an alcohol wipe, per facility policy. Additionally, s/he failed to wear a gown when handling the resident's catheter.During a surveyor interview following the above observation with Staff A, she acknowledged that she did not wear a gown nor clean the catheter/drainage bag tubing with an alcohol wipe prior to reconnecting them and revealed that she should have.During a surveyor interview on 4/29/2026 at 10:04 AM with the Director of Nursing Services (DNS), she acknowledged that Staff A should have worn a gown when handling the resident's indwelling catheter and would have expected her to have cleaned the tubing and catheter with an alcohol wipe prior to reconnecting them. 2. Review of a facility policy titled, Resident Vaccination (Flu and pneumonia) states in part, .Vaccinations are to be provided in accordance with the most recent ACIP (Advisory Council on Immunization Practices) guidelines for these vaccinations.Persons [AGE] years of age or over who have never received a pneumonia vaccination (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
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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	should receive PCV13.Further review revealed the policy was last revised 4/1/2026.According to current ACIP guidelines, the pneumonia vaccine, PCV13, is no longer recommended nor available for administration within the United States.During a surveyor interview on 4/29/2026 at 11:23 AM with the DNS, she revealed that the facility follows current ACIP guidelines and acknowledged that their policy is not up to date with the current guidelines according to the ACIP.