STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415049	A. Building B. Wing	01/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Haven Operations LLC Dba Lake Forrest Health	180 Log Road Smithfield, RI 02917

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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 - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, surveyor observation, staff and resident interview the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections relative to an unidentified respiratory illness for 2 of 3 nursing units and affecting Resident ID #s 7, 18, 29, 34, 36, 59, 62, 64, and 97. Additionally the facility failed to routinely clean a BiPap machine (a noninvasive ventilation that helps you breathe) for Resident ID #1. Furthermore, the facility failed to follow transmission-based precautions for 3 of 6 resident's reviewed, Resident ID #s 6, 14, and 39. Findings are as follows:1. According to the Viral Respiratory Pathogens Toolkit for Nursing Homes dated 12/11/2025 from the Centers of Disease Control (CDC) and Prevention states in part, .When an acute respiratory infection is identified in a resident or [healthcare personnel, HCP], it is important to take rapid action to prevent the spread to others in the facility.While decisions about treatment, prophylaxis, and the recommended duration of isolation vary depending on the pathogen, [infection prevention control] strategies, such as placement of the resident in a single-person room, use of a facemask for source control, and physical distancing, are the same regardless of the pathogen .[Healthcare personnel] who enter the room of a resident with signs or symptoms of an unknown respiratory viral infection that is consistent with SARS-CoV-2 [covid-19] infection should adhere to Standard Precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). This PPE [personal protective equipment] can be adjusted once the cause of the infection is identified .Test residents and HCP with new respiratory illness signs or symptoms. Selection of diagnostic tests will depend on the suspected cause of the infection (e.g., which respiratory viruses are circulating in the community or the facility, recent contact with someone confirmed to have a specific respiratory infection) and if the results will inform clinical management (e.g., treatment, duration of isolation). At a minimum, testing should include SARSCoV-2 and influenza viruses with consideration for other causes (e.g., RSV) .Review of a facility policy titled Isolation states in part, It is the policy of this facility to prevent the spread of infection within the facility through the use of isolation precautions.transmission-based precautions, as defined by the CDC, will be employed for known or suspected infections for which the route/prevention is known.1a. Record review revealed Resident ID #59 was admitted to the facility in December of 2025 with diagnoses including, but not limited to, Respiratory Syncytial Virus (RSV) and pneumonia. Record review revealed the resident was on transmission-based precautions due to the diagnosis of RSV.1b. Record review revealed Resident ID #62 was admitted to the facility in December of 2025 with a diagnosis including, but not limited to, bipolar disorder.Record review revealed the resident was sent to the hospital on [DATE] for complaints of chest pain and returned to the facility on [DATE] with a diagnosis of RSV.1c. Record review revealed Resident ID #7 was readmitted to the facility in January of 2022 with diagnosis including, but not limited to, bipolar disorder and dementia.Record review revealed a physician's order with a start date of 12/23/2025 and an end date of 12/26/2025 for Guaifenesin Syrup (a cough suppressant) every 6 hours for 3 days.Record review failed to reveal evidence that an RSV, covid-19, or influenza swabs were obtained related to recent RSV positive (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	residents in the building or that the resident was placed on transmission-based precautions.During surveyor observations on 12/29/2025 and 12/30/2025 failed to reveal evidence that the resident was placed on precautions related to signs and symptoms that are consistent with a communicable disease or infection.1d. Record review revealed that Resident ID #18 was admitted to the facility in March of 2022 with a diagnosis including, but not limited to, dementia.Record review revealed a physician's order for Guaifenesin Syrup every 6 hours as needed for cough.Review of the December 2025 Medication Administration Record (MAR) revealed the resident received the Guaifenesin cough medication on 12/23/2025 and 12/26/2025. Record review failed to reveal evidence that an RSV, Covid-19, or influenza swabs were obtained related to recent RSV positive residents in the building, the facility policy, or that the resident was placed on transmission-based precautions.During surveyor observations on 12/29/2025 and 12/30/2025 failed to reveal evidence that the resident was placed on precautions related to signs and symptoms that are consistent with a communicable disease or infection, until it was brought to the facility's attention by the surveyor.1e. Record review revealed that Resident ID #29 was admitted to the facility in March of 2021 with a diagnosis including, but not limited to, dementia.Record review revealed the resident presented with increased lethargy, poor appetite and cough on 12/22/2025. The provider was notified, and orders were obtained for an immediate chest x-ray, to administer duoneb (a medication that is inhaled for shortness of breath) ever 6 hours for 3 days, and if symptoms worsen to obtain a respiratory panel to test for covid-19, influenza and RSV.Record review revealed the resident was tested for Covid-19 on 12/22/2025.Record review failed to reveal evidence that RSV or influenza swabs were obtained related to recent RSV positive residents in the building, the facility policy, or that the resident was placed on transmission-based precautions.During surveyor observations on 12/29/2025 and 12/30/2025 failed to reveal evidence that the resident was placed on precautions related to signs and symptoms that are consistent with a communicable disease or infection, until it was brought to the facility's attention by the surveyor. 1f. Record review revealed that Resident ID #34 was admitted to the facility in October of 2025 with a diagnosis including, but not limited to, dementia.Record review revealed the resident complained of cold like symptoms on 12/28/2025.Record review revealed the resident was tested for Covid-19 on 12/28/2025.Record review failed to reveal evidence that RSV or influenza swabs were obtained related to recent RSV positive residents in the building, facility policy, or that the resident was placed on transmission-based precautions.During surveyor observations on 12/29/2025, 12/30/2025 and 12/31/2025 failed to reveal evidence that the resident was placed on precautions related to signs and symptoms that are consistent with a communicable disease or infection, until it was brought to the facility's attention by the surveyor.1g. Record review revealed Resident ID #36 was admitted to the facility in July of 2023 with a diagnosis including, but not limited to, dementia.Record review revealed the resident complained of cold like symptoms on 12/28/2025.Record review revealed the resident was tested for Covid-19 on 12/28/2025.Review of the December 2025 MAR revealed the resident received Guaifenesin cough medication on 12/29/2025. Further record review revealed that on 12/30/2025, the resident was noted in respiratory distress and was sent to the hospital and admitted for pneumonia and influenza A.Record review failed to reveal evidence that RSV or influenza swabs were obtained related to recent RSV positive residents in the building, facility policy, or that the resident was placed on transmission-based precautions.During a surveyor observation on 12/29/2025, failed to reveal evidence that the resident was placed on precautions related to signs and symptoms that are consistent with a communicable disease or infection.1h. Record review revealed Resident ID #64 was admitted to the facility in May of 2024 with a diagnosis including, but not limited to, depression. Review of the December 2025 MAR revealed the resident received Guaifenesin cough medication on 12/21/2025.Record review revealed the resident complained of cold like symptoms, increased shortness of breath, had abnormal breath sounds, and a nonproductive cough on 12/23/2025.Record review failed to reveal evidence that an RSV, Covid-19, or influenza swabs were obtained related to recent RSV positive residents in the building, the facility (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	policy or that the resident was placed on transmission-based precautions.During surveyor observations on 12/29/2025, 12/30/2025 and 12/31/2025, failed to reveal evidence that the resident was placed on precautions related to signs and symptoms that are consistent with a communicable disease or infection, until it was brought to the facility's attention by the surveyor.1i Record review revealed Resident ID #97 was admitted to the facility in June of 2025 with diagnoses including, but not limited to, chronic obstructive pulmonary disorder and chronic respiratory failure.Review of the December 2025 MAR revealed the resident received the Guaifenesin cough medication on 12/26/2025 and 12/28/2025 for complaints of a cough. Record review revealed the resident complained of cold like symptoms on the following dates:12/25/2025: complaint of not feeling well with nasal congestion, shortness of breath with exertion.12/30/2025: complaint of productive cough and upper airway congestion.Record review failed to reveal evidence that RSV, Covid-19, or influenza swabs were obtained related to recent RSV positive residents in the building, the facility policy, or that the resident was placed on transmission-based precautions.During surveyor observations on 12/29/2025 and 12/30/2025 failed to reveal evidence that the resident was placed on precautions related to signs and symptoms that are consistent with a communicable disease or infection, until it was brought to the facility's attention by the surveyor.During a surveyor interview with the Infection Preventionist (IP) on 12/30/2025 at 1:06 PM, during the infection control task, he acknowledged that he was aware of a resident who had RSV. Additionally, he revealed he was aware of other residents with cold like symptoms but revealed he did not test any additional residents for RSV, influenza, or place them on transmission-based precautions. When presented with the list of residents who were symptomatic with a respiratory illness, he was unable to provide evidence of a tracking mechanism used to detect possible communicable diseases or infections and that the respiratory illness was identified and managed to prevent a potential outbreak of disease.Review of an email from the Rhode Island Department of Health Infectious Disease Surveillance Nurse, revealed that she recommended to the facility to implement empiric-based precautions for new respiratory symptoms (Empiric precautions are used when a resident presents with symptoms that may indicate an infectious disease, but the specific pathogen has not yet been identified. These precautions are critical in protecting healthcare workers and other residents from potential infections).During a surveyor interview with the Director of Nursing Services (DNS), on 12/31/2025 at 9:53 AM, she revealed that she was in contact with the Rhode Island Department of Health Infectious Disease Surveillance Nurse, who notified her over the phone to test residents who were developing symptoms of a respiratory virus. Additionally, she was unable to provide evidence that the above-mentioned residents were tested according to the facility policy and guidance until it was brought to the facility's attention by the surveyor. 2. Review of an undated facility policy titled CPAP and BIPAP VENTILATORY SYSTEMS, states in part, .It is the policy of this facility to ensure that ventilatory support is provided appropriately for patients diagnosed with obstructive sleep apnea.cleaning and Maintenance:.Mask or pillow and tubing will be cleansed with warm soapy water at least weekly.Mask or pillow and tubing should be inspected and changed per manufacture guidelines.Any consistent refusal to use equipment should be reported to the physician.Record review revealed that Resident ID #1 was readmitted to the facility in April of 2025 with a diagnosis including, but not limited to, obstructive sleep apnea.Record review revealed that the resident utilizes a BiPap machine at night.During a surveyor interview on 12/31/2025 at 8:03 AM, with the resident, s/he revealed that s/he uses the BiPap machine at night but that the machine has not been cleaned since s/he started using it.During a surveyor interview on 12/31/2025 at 8:05 AM with Licensed Practical Nurse, Staff A, she revealed that they should be cleaned on Tuesdays and that a task would populate in the MAR to be completed. Additionally, when asked by the surveyor about Resident ID #1's BiPap, she revealed that she was unable to find an order to clean his/her BiPap. Furthermore, she revealed that the respiratory therapist might clean the machine.During a surveyor interview with the DNS on 12/31/2025 at 8:12 AM, she revealed that she believed the respiratory therapist cleaned the machines. Additionally, she acknowledged there was not an order in (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	place to clean the machine and would expect the machines to be cleaned weekly and as needed and was unable to provide evidence that this was being completed.During a surveyor interview on 12/31/2025 at 8:16 AM, with the Respiratory Therapist, she revealed that she does not clean the tubing or the masks. She indicated she may use a wipe to clean the outside of the machine but does not take it apart to clean. 3. Review of a facility policy titled Isolation states in part, It is the policy of this facility to prevent the spread of infection within the facility through the use of isolation precautions.transmission based precautions, as defined by the CDC, will be employed for known or suspected infections for which the route/prevention is known.3a. Record review revealed that Resident ID #6 was admitted to the facility in July of 2023 with a diagnosis including, but not limited to, dementia.Review of the resident's room on 12/31/2025, revealed signage posted outside the door to utilize contact and droplet precautions (the use of gown, gloves, mask and face shield) upon entering the resident room.Record review revealed an order dated 12/31/2025 which states in part, resident placed on contact and Droplet precautions 2nd to respiratory panel testing = every shift for prevention until result is in then re-evaluate.During a surveyor observation on 12/31/2025 at 11:58 AM, revealed LPN, Staff C enter Resident ID #6's room with his mask pulled down under his chin. Further, Staff C failed to wear a gown, face shield, and gloves when he entered Resident ID #6's room as required per the signage. Additionally, when Staff C exited Resident ID #6's room, went to the medication cart, and then immediately went into another resident's room, without performing hand hygiene.During a surveyor interview on 12/31/2025 at 11:59 AM with Staff C, he revealed the resident was on contact/droplet precautions due to being swabbed for a respiratory infection. He indicated that he entered the resident's room, and acknowledged the signage posted outside the room indicating what personal protective equipment is required. Further, he acknowledged that he should have worn a gown, face shield, gloves and his mask appropriately, so it was covering his nose and mouth prior to entering the resident's room.3b. Record review revealed that Resident ID #14 was admitted to the facility in December of 2025 with a diagnosis including, but not limited to, acute kidney failure.Review of the resident's room on 1/2/2026, revealed signage posted outside the door to utilize contact and droplet precautions upon entering the resident room.During a surveyor observation on 1/2/2026 at 9:45 AM, revealed Nursing Assistant (NA), Staff L, coming out of the resident's room without wearing a face shield. Staff L then took the resident to the shower. Staff L exited the shower room wearing the same gown and gloves used during care and proceeded to bring the resident back to his/her room. Staff L exited the resident's room into the main hallway while wearing the same gown and gloves in the hallway. Staff L then reentered the room to finish care without donning a face shield. During a surveyor interview with Staff L, she acknowledged that she failed to wear a face shield during care and wore her protective equipment in the hallway and failed to remove them after care. During a surveyor interview on 1/2/2026 at 10:23 AM with Registered Nurse, Staff E, he revealed that the resident was on precautions and would expect the staff to follow the signage.3c. Record review revealed that Resident ID #39 was admitted to the facility in June of 2020 with a diagnosis including, but not limited to, urinary tract infection.Record review revealed a physician's order with a start date of 3/17/2025 for enhanced barrier precautions, to utilize a gown and glove for care.Record review revealed a care plan initiated on 9/25/2024, which states in part, .Resident on Enhanced Barrier Precautions for [Carbapenem-resistant Enterobacterales, a multidrug resistant organism] colonization.During a surveyor observation on 12/29/2025 at 11:45 AM revealed a Hospice Nursing Assistant (NA), Staff M, in the resident's room providing morning care. Further observation failed to reveal evidence of the use of a gown during the care.During a surveyor interview on 12/29/2025 at 11:46 AM with LPN, Staff I, she acknowledged that Staff M was not wearing a gown and should have.During a surveyor interview with the DNS on 1/2/2026 at 10:41 AM, she revealed that she would expect all staff including hospice staff to utilize the use of the appropriate protective equipment per the signage posted on the door and would expect staff to perform hand hygiene when exiting a room whose resident is on precautions.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on clinical record review and staff interview, the facility failed to follow and implement a physician's order relative to the administration of insulin for 1 of 3 residents reviewed, Resident ID #3. Additionally, the facility failed to follow and implement physician's orders relative to the facility's Bowel Protocol for 2 of 2 residents reviewed who did not have a bowel movement (BM) for more than three days, Resident ID #s 8 and 77.Findings are as follows: 1. Review of the facility's undated policy titled, Medication Administration states in part, .If a resident refused the medication .Complete the information indicating the refusal inclusive of the reason, if known. Consistent refusals require notification to the attending physician and the nurse management.Record review revealed Resident ID #3 was admitted to the facility in May of 2022 with a diagnosis including, but not limited to, diabetes.Record review revealed a physician's order dated 4/3/2024 for Trulicity injection (a medication prescribed to treat diabetes) 0.74 milligrams (mg) once a week, on Wednesdays in the morning.Record review of the 2025 Medication Administration Records (MAR) revealed staff documented that the resident refused his/her Trulicity for 16 of 20 opportunities on the following dates: - August 20 and 27- September 3, 10, 17, and 24 - October 1, 8, 15, and 22 - November 5, 12, and 19 - December 10, 17, and 24Record review failed to reveal evidence that the attending physician and nurse management were notified that Resident ID #3 had refused his/her Trulicity on the above-mentioned dates, as required by the facility policy.During a surveyor interview on 12/30/2025 at 11:55 AM with Licensed Practical Nurse, Staff C, he indicated that he was unaware the resident had been regularly refusing his/her Trulicity on a weekly basis.During a surveyor interview on 12/30/2025 at 12:25 PM with Nurse Practitioner, Staff D, she revealed that she did not recall being notified of the resident's refusals and indicated she would have expected the staff to have notified her. She further indicated that if she had been informed, she would have re-evaluated the resident and adjusted the plan of care.During a surveyor interview on 12/30/2025 at 12:35 PM with the Director of Nursing Services (DNS), she acknowledged that she was unaware of the above-mentioned refusals and indicated that she would expected the staff to have notified both the physician and nursing leadership of the repeated refusals of the Trulicity. 2. Review of a facility's policy titled, Bowel Protocol dated 5/25/2021 states in part, .Each unit will review the report for residents that have not had a bowel movement or a small bowel movement in three days.The bowel protocol will begin as follows (unless contraindicated): the CMT [Certified Medication Technician] or nurse will administered the following: 3-11 shift administer 30 [milliliter] ml of Milk of Magnesium [MOM- a medication prescribed to treat constipation] and document it in the EMR [electronic medical record]. If no bowel movement by the end of the shift, then the 11-7 nurse will be made aware. 11-7 shift will verify that a resident has or had not had a bowel movement. If the resident had not had a bowel movement, the 11-7 nurse will administer a Dulcolax [a medication prescribed to treat constipation] suppository in the AM prior to the end of the shift. The nurse will report the 7-3 nurse the results of the suppository. 7-3 shift will administer a Fleet enema [a medication prescribed to treat constipation] in the morning and document the results. If there are no results from the above measures, the nurse will notify nursing management and the MD [medical doctor] for further interventions.a. Record review revealed Resident ID #8 was readmitted to the facility in October of 2021 with diagnoses including, but not limited to, dementia and constipation.Record review of the December 2025 and January 2026 Medication Administration Records (MAR) revealed the following physician's orders:- Prune juice 8 ounces every 24 hours as needed for constipation if no BM in 72 hours, give in AM.- Milk of Magnesia suspension 400 mg/5 ml (milligrams/milliliter), give 30 mL every 24 hours for constipation if no BM in 72 hours, give 30 ml on the 3-11 shift, if no results from the prune juice.Review of Resident ID #8s bowel log failed to reveal evidence of any bowel movements for five days from 12/28/2025 through 1/1/2026. Further review of the MAR failed to reveal evidence that any of the above medications were administered after three days (72 hours) without a bowel (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	movement, as ordered until it was brought to the facility's attention by the surveyor on 1/2/2026.b. Record review revealed Resident ID #77 was admitted to the facility in October of 2025 with a diagnosis including, but not limited to, end stage renal disease (kidney failure). Record review of the December 2025 MAR revealed a physician's order dated 10/16/2025 for Bisacodyl, insert 1 suppository rectally as needed for constipation if no BM in 72 hours, give on the 11-7 shift if no BM results after MOM.Review of the bowel log for Resident ID #77 revealed the following:- No BM from 12/6/2025 through 12/9/2025 (four days)- No BM from 12/20/2025 through 12/26/2025 (seven days)Further review of the MAR failed to reveal evidence that the Bisacodyl suppository was administered after three days without a BM, as ordered.During a surveyor interview on 1/2/2026 at 9:40 AM with Registered Nurse, Staff E, he acknowledged that Resident ID #8 did not have a BM documented for 5 days from 12/28/2025 through 1/1/2026. Additionally, Staff E acknowledged that Resident ID #77 did not have a BM documented for four days from 12/6/2025 through 12/9/2025 and for seven days from12/20/2025 to 12/26/2025. Staff E was unable to provide evidence that the bowel protocol or physician's orders were followed for the residents.During a surveyor interview on 1/2/2026 at 1:10 PM with the Director of Nursing Services, she was unable to provide evidence the bowel protocol and physician's orders were followed for Resident ID #s 8 and 77.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on clinical record review and staff interview, the facility failed to implement and maintain an effective training program for all employees, consistent with their expected roles, as outlined in the Facility Assessment relative to education on the use and maintenance of Bi-PAp (A bilevel positive airway pressure machine- a type of noninvasive ventilation that helps individuals breathe by delivering pressurized air through a mask) and C-Pap (a continuous positive airway pressure machine- a type of medical device that is prescribed to treat sleep apnea by delivering a constant stream of pressurized air to keep the airways open during sleep) for 5 of 5 nurses reviewed, Staff C, E, G, H, and K. Findings are as follows:Review of the Facility Assessment dated 7/16/2025 revealed, Existing Competency.on hire, quarterly, annually.Respiratory: Trach, C-Pap , Bi-Pap.Record review failed to reveal evidence of Staff C, E, G, H and K completing a competency-based education relative to the use or maintenance of a C-Pap or Bi-Pap machine.During a surveyor interview on 12/31/2025 at 11:13 AM with the Staff Developer, he acknowledged that staff have not completed training related to the use or maintenance of a C-Pap or Bi-Pap machine although it is listed as an existing competency in the facility assessment.During a surveyor interview on 12/31/2025 at 1:36 PM with the Director of Nursing Services she was unable to provide evidence that the facility provided competency-based education on C-Pap or Bi-Pap use to any of its nursing staff including Staff C, E, G, H and K.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on clinical record review, surveyor observation and staff interview, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, for 1 of 1 resident reviewed for a fluid restriction, Resident ID #35.Findings are as follows:Review of a policy titled, I & O [intake and output] - Fluid Restriction, last revised 3/15/2024, states in part, .Process: 1. Verify order: order must include volume or range of fluid permitted during a 24-hour period. 2. Notify Dietary Department using Diet Order Communication Form. 2.1 Dietary to calculate amount of fluids to be provided on meal trays. 3. Calculate remaining amount of fluids to be provided by nursing. 3.1 Calculate amount allotted for each shift. 4. Monitor fluid intake.Record review revealed the resident was admitted to the facility in November of 2025 with a diagnosis including, but not limited to, alcoholic cirrhosis of the liver with ascites (a severe condition caused by chronic alcohol abuse, leading to liver damage and fluid accumulation in the abdomen). Review of a care plan focus area initiated on 11/8/2025 revealed the resident has fluid overload or the potential for fluid volume overload, related to his/her disease process of cirrhosis with ascites. Interventions include, but are not limited to, provide diet as ordered.Record review revealed a physician's diet order dated 11/13/2025, for a 2-gram sodium diet, regular texture, and a fluid restriction of 1500 milliliters (mL).Further review of the above physician's order failed to reveal evidence of calculated fluid amounts to be provided on his/her meal tray. Further record review failed to reveal evidence of any calculated fluid amounts to be provided by nursing, per the facility policy.Review of the resident's dietary slip dated 12/30/2025 revealed s/he is on a 1500 mL fluid restriction. Further review failed to reveal evidence of calculated fluid amounts to be provided on his/her meal trays.During a surveyor observation on 12/30/2025 at 8:07 AM, the resident was noted to have 480 mL of fluids during breakfast.During a surveyor observation on 12/30/2025 at 11:41 AM, the resident was noted to have a 480 mL of soda at his/her bed side. Review of a paper tracker dated 12/30/2025 revealed the resident consumed 240 mL of fluids during breakfast, 480 mL of fluids during lunch, and 480 mL of fluids during dinner.Review of the computer task, which asks the question: How much did the resident drink (in mL), revealed that on 12/30/2025, s/he consumed 240 mL at breakfast, 240 mL at lunch, and 360 mL at dinner.Record review and surveyor observation of the above-mentioned documentation revealed inconsistencies with the amounts of fluid the resident consumed with his/her meals. During a surveyor observation and interview with the resident on 12/31/2025 at 7:41 AM, s/he was observed with 1070 mL at breakfast, 2 cups of 240 mL of fluid, 1 cup of 120 mL of fluid and a 470 mL bottle of soda. The resident revealed that s/he frequently visits the vending machine to buy a bottle of soda. Record review of the resident's fluid intake from meals and additional fluids documented in the electronic medical record revealed the following documentation:-12/1/2025 missing breakfast and lunch intake-12/6/2025 missing dinner intake-12/8/2025 consumed 2160 mL of fluids-12/12/2025 consumed 1560 mL-12/14/2025 consumed 1800 mL-12/17/2025 missing lunch meal documentation -12/21/2025 missing dinner intake -12/22/2025 consumed 1560 mL-12/23/2025 consumed 1560 mL -12/24/2025 missing dinner intake-12/27/2025 consumed 1560 mLDuring a surveyor interview on 12/31/2025 at 8:02 AM, with Licensed Practical Nurse, Staff A, she revealed that nursing staff do not total the resident's fluid intake per shift, including fluids provided during medication pass. Further, she revealed that they do not track what the resident receives on his/her meal tray. Lastly, she revealed that the resident will go to the vending machine to obtain his/her own soda and was unable to provide evidence where that was reflected in the medical record. During a surveyor interview on 12/31/2025 at 8:07 AM, with Nursing Assistant (NA), Staff B, she revealed that the NA who collects the resident's meal tray, documents the resident's fluid intake on a paper tracker and the NA assigned to the resident each shift documents as a task in the computer.During a surveyor interview on 12/31/2025 at 9:49 AM, with the Director of Nursing Services and the Administrator, they revealed that the resident's fluid restriction should be broken down, per facility policy by the amount for (continued on next page)

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Cedar Haven Operations LLC Dba Lake Forrest Health	180 Log Road Smithfield, RI 02917

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dietary and the amount for nursing to administer. Additionally, she acknowledged that there were inconsistencies with the documentation of fluid intake and that the staff were unaware of how much fluid the resident was actually consuming.

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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. Based on clinical record review, surveyor observation, and staff interview, the facility failed to ensure that each resident received adequate supervision and assistive devices for 1 of 1 resident reviewed for elopement, Resident ID #2. Findings are as follows:Review of an undated policy titled, Wanderguard System and Assessments; Check states in part, .The wanderguard bracelet will be applied to the resident's person. There may be an occasion when the resident will not allow application; if that is the case, the nurse manager/designee will determine next best placement options (i.e., walker, wheelchair). The bracelet will be checked each shift to assure placement; the nurse will sign this as checked in the treatment record.Record review revealed the resident was readmitted to the facility in November of 2024 with a diagnosis including, but not limited to, bipolar disorder.Review of a care plan focus area last revised 12/16/2025 revealed the resident is an elopement risk/wanderer, related to impaired safety awareness. Further review revealed the resident wanders aimlessly and had an elopement attempt on 12/16/2025. Interventions include, but are not limited to, residing on a secure unit and a wanderguard to his/her right arm.Record review revealed a progress note dated 12/16/2025 which states in part, resident with elopement attempt this afternoon, resident kicked the secure unit door and was able to make [his/her] way into the Lobby area, then [s/he] proceeded toward the front door, resident exited the building into parking lot. receptionist notified north B unit while she kept watching resident in parking lot, this nurse also notified, 2 CNA [Certified Nursing Assistants] and this nurse in parking lot with resident [s/he] was assisted into building and then into [his/her] unit, MD [Medical Doctor] notified with order to place wander guard on resident. new wander guard placed to resident [right] arm.Record review revealed the following physician's orders dated 12/16/2025:- Resident has wanderguard to the right arm, where staff are to check placement every shift- Check wanderguard functionality every night shift, for safetyReview of the December 2025 Medication Administration Record revealed the above wanderguard orders were signed off as completed. Additional record review revealed a progress note dated 12/28/2025 which states in part, .removed [his/her] wander guard handing it to staff no verbalization that [s/he] wanted to leave facility.During surveyor observations on 12/30/2025 at 11:07 AM and 12/31/2025 at 12:02 PM, no wander guard was noted on the resident's right wrist.During a surveyor interview on 12/31/2025 at 12:07 PM, with Licensed Practical Nurse, Staff C, he acknowledged that the resident did not have a wanderguard on his/her right wrist, as ordered.During a surveyor interview on 12/31/2025 at 12:09 PM, with Nursing Assistant, Staff F, she revealed that the resident's wanderguard was taken off the unit by the Director of Nursing Services (DNS) on 12/30/2025, indicating that the resident has not had it on, as ordered.During a surveyor interview on 12/31/2025 at 12:15 PM, with the DNS, she revealed that the resident had a recent elopement attempt and the wanderguard was ordered as a safety intervention. She further revealed that she was unaware that this resident did not have his/her wanderguard on and was unaware the wanderguard she removed from the unit belonged to this resident, indicating she was under the impression it was an extra wanderguard.Record review failed to reveal evidence that after the resident removed his/her wanderguard that the facility implemented any additional interventions to prevent a potential elopement.

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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. Based on surveyor observation, clinical record review, resident, and staff interviews, the facility failed to provide respiratory care consistent with professional standards of practice for 1 of 2 residents reviewed for oxygen use, Resident ID #97. 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 an undated facility policy titled, Policy for Oxygen Management & Labeling Equipment states in part, .Oxygen therapy must be prescribed by a physician. The prescribed flow rate and delivery method must be documented in the patient's medical record.Record review revealed the resident was admitted to the facility in June of 2025 with diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD, an ongoing lung condition caused by damage to the airways and other parts of the lungs) and chronic respiratory failure with hypercapnia (a condition where there are abnormally high levels of carbon dioxide in the blood that could be caused by conditions like COPD).Review of the care plan dated 6/16/2025 revealed that the resident utilizes oxygen at 2 liters (L) continuously. 1a. Review of a physician's order dated 6/16/2025 revealed to administer oxygen at 2L every shift. Surveyor observations revealed the resident was receiving 5 liters (L) of oxygen instead of 2L, as ordered on the following dates and times:- 12/29/2025 at 12:48 PM- 12/30/2025 at 8:29 AM, 12:37 PM, 12:58 PM, and at 1:56 PM.During a surveyor interview with the resident on 12/30/2025 at approximately 1:00 PM, s/he indicated that his/her oxygen should be at 2L and indicated that the nurse sets up the oxygen.During a surveyor interview on 12/30/2025 at 1:59 PM with Licensed Practical Nurse, Staff C, he indicated the resident should be receiving 2-4L of oxygen. The surveyor then asked Staff C to review the order in the resident's electronic record; after reviewing the order, Staff C acknowledged the oxygen order was for 2L and not 2-4 L as he had previously indicated.During a surveyor observation and interview on 12/30/2025 at 2:00 PM in the presence of Staff C, he acknowledged the resident was receiving 5L of oxygen instead of 2L as ordered. Staff C then asked the resident if s/he had changed the oxygen liter flow and the resident denied changing the oxygen from 2L to 5L.1b. Record review revealed a physician's order dated 6/17/2025 to change the oxygen tubing weekly every Tuesday.Record review of the December 2025 Treatment Administration Record (TAR) revealed the order was signed off as completed on 12/30/2025.During a surveyor observation on 12/31/2025 at 9:16 AM in the presence of Registered Nurse, Staff E, revealed the resident was receiving oxygen via tubing that was dated 12/24/2025.During a surveyor interview with Staff E immediately following the above-mentioned observation, he acknowledged the oxygen tubing was dated 12/24/2025.During a surveyor interview on 12/31/2025 at 1:39 PM with the Director of Nursing Services, she indicated that she would have expected the resident to be receiving oxygen at 2L, as ordered. Additionally, she was unable to provide evidence the oxygen tubing was changed weekly as ordered.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on clinical record review and staff interview, the facility failed to ensure that pain management is provided to residents who require such services, for 1 of 1 resident reviewed for pain management, Resident ID #12. Findings are as follows: Review of the facility policy titled, Pain Assessment, states in part, .interventions will be required for.any pain that is not managed.if the residents comfort goal has not been met.residents who experience pain shall have.the problem indicated on their care plan together with interventions and measurable goals for elimination of pain. 1a. Record review revealed that Resident ID #12 was admitted to the facility in April of 2025 with diagnoses including, but not limited to, Critical illness polyneuropathy (a condition characterized by acute or subacute onset of symmetric muscle weakness in critically ill patients), muscle spasm, and fracture of sacrum (coccyx).Record review revealed the resident had a significant change in status Minimum Data Set (MDS) Assessment on 10/15/2025. The resident was identified to have pain and was triggered in the Care Area Assessment (CAA) Summary and CAA Worksheet. Review of the CAA Summary and CAA Worksheet revealed a plan to proceed to the resident's care plan to address the resident's pain. Review of the resident's care plan failed to reveal evidence that the care plan was initiated for pain. During a surveyor interview on 12/31/2025 at 12:03 PM, with the MDS Nurse, Staff G, she acknowledged that the resident triggered on his/her MDS for pain. Additionally, she acknowledged that the CAA worksheet and summary indicated that a care plan for pain would be initiated. Furthermore, she was unable to explain why a care plan was not initiated for the resident's pain. During a surveyor interview on 12/31/2025 at 12:49 PM, with the Director of Nursing Services (DNS), she revealed that she would expect the resident to have a care plan for pain in place. 1b. Record review revealed an order that states in part, Monitor pain daily. Review of the December 2025 Medication Administration Record (MAR) revealed the resident's pain was monitored every other day and not daily as ordered. During a surveyor interview with the MDS Nurse, Staff H, on 12/31/2025 at 12:04 PM, she revealed that she transcribed the order incorrectly to only populate every other day. She revealed that the order should have been to monitor pain daily and not every other day. During a surveyor interview on 12/31/2025 at 12:40 PM with the DNS, she revealed that she would expect the order to be transcribed correctly, and that the resident's pain should be monitored daily and not every other day. 1c. Record review revealed the resident complained of pain on a scale of 1-10 1 being the least 10 being the worst, on the following dates and times: - 12/12/2025 at 10:23 AM with a rating of 2- 12/14/2025 at 11:00 AM with a rating of 4- 12/18/2025 at 9:59 AM with a rating of 3- 12/22/2025 at 1:07 PM with a rating of 3- 12/24/2025 at 10:57 AM with a rating of 7Record review revealed a physician's order for Tramadol HCl Oral Tablet 50 milligrams (mg). Give 50 mg by mouth four times a day scheduled at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. Record review revealed the following as needed medications for pain management:- Acetaminophen Tablet 325 milligrams (mg) Give 2 tablet orally every 6 hours as needed for pain with a start date of 11/7/2025 - tramadol HCl Oral Tablet 50 mg (Tramadol HCl) Give 50 mg by mouth every 12 hours as needed for moderate breakthrough pain with a start date of 11/23/2025- Biofreeze Cool the Pain External Gel 4 % apply to bilateral legs topically every 6 hours as needed for pain. Record review failed to reveal evidence that the resident's complaints of pain on 12/12, 12/14, 12/18, 12/22, and 12/24/2025 were addressed with pharmacological or non-pharmacological interventions (a way to manage pain without medicine, examples include but are not limited to, repositioning relaxation techniques, music, heat or ice). During a surveyor interview with Licensed Practical Nurses, Staff A and I, on 12/31/2025 at 12:44 PM, they revealed that they were unable to find documentation of the resident's pain being addressed on 12/12, 12/14, 12/18, 12/22, and 12/24/2025 when s/he complained of break through pain. During a surveyor interview on 12/31/2025 at 12:49 PM with the DNS, she revealed that she would expect staff to utilize pharmacological or non-pharmacological interventions for pain management for the resident and was unable to provide evidence that pharmacological or non-pharmacological interventions were utilized on the above-mentioned dates.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on clinical record review, resident and staff interview, the facility failed to keep all residents free from significant medication errors for 1 of 1 resident reviewed who received his/her roommate's medication in error, Resident ID #5 and for 1 of 1 resident reviewed whose medication was omitted, Resident ID #53. Findings are as follows:Review of an undated facility policy titled, Medication Administration states in part, It is the intent of this policy to ensure that resident medication administration is managed to ensure for resident quality of life, timeliness and safety.Prior to administration ensure: The right resident, Identify by bracelet, photo or other means.1. Record review revealed Resident ID #5 was admitted to the facility in October of 2025 with diagnoses including, but not limited to, chronic pain syndrome and multiple sclerosis.During a surveyor interview on 12/31/2025 at 11:27 AM with Resident ID #5, s/he revealed that at the beginning of the month an agency nurse gave him/her another resident's medication. Per Resident ID #5 the nurse did not identify him/her and told him/her that the medication in the cup was for them. Additionally, Resident ID #5 revealed that s/he took the medication and then the nurse asked him/her what his/her name was.Record review revealed a progress note authored by the Director of Nursing Services (DNS), dated 12/11/2025 that states in part, While passing meds this afternoon agency nurse went into resident's room and called the roommate's name. [Resident ID #5] responded and the nurse reports she asked [him/her] name and [Resident ID #5] responded. The nurse then stated I have your Oxy 5mg [Oxycodone 5 milligrams]. [Resident ID #5] took the medication and immediately swallowed it. [S/he] then turned to the nurse and laughed and stated 'oh I am not that patient. That is my roommate'.Review of a Medication Error Report dated 12/11/2025 revealed Licensed Practical Nurse, Staff J, administered Resident ID #5 his/her roommate's medication due to her failure to identify the resident.During a surveyor interview on 12/31/2025 at 11:58 AM with the DNS she acknowledged that Resident ID #5 was administered his/her roommate's medication due to Staff J, not appropriately identifying the resident.2. Record review revealed that Resident ID #53 was admitted to the facility in August of 2025 with diagnoses including, but not limited to, dementia and anxiety.Record review revealed a physician's order for Seroquel 50 mg (an antipsychotic) daily in the afternoon.Review of the December 2025 Medication Administration Record revealed that on 12/28/2025 the Seroquel was not administered as ordered. During a surveyor interview on 1/2/2026 at 10:37 AM with the DNS she was unable to explain why the Seroquel was not administered on 12/28/2025 to Resident ID #53. Additionally, the DNS was unable to provide evidence that the facility kept Resident ID #s 5 and 53 free from significant medication errors.

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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 1 of 1 resident reviewed for elopement, Resident ID #2 and for 1 of 1 resident reviewed for Narcan (a medication that can reverse an opioid overdose), Resident ID #28 and 1 of 1 resident reviewed whose medication was omitted, Resident ID #53.Findings are as follows:1. Review of an undated facility policy titled, Wanderguard System and Assessments; Check states in part, .The wanderguard bracelet will be applied to the resident's person.The bracelet will be checked each shift to assure placement; the nurse will sign this as checked in the treatment record.Record review revealed the resident was readmitted to the facility in November of 2024 with a diagnosis including, but not limited to, bipolar disorder.Record review revealed the following physician's orders dated [DATE]:- Resident has wanderguard to the right arm, where staff are to check placement every shift- Check wanderguard functionality every night shift, for safetyRecord review revealed a progress note dated [DATE] at 4:46 PM, which states, .removed [his/her] wander guard handing it to staff .no verbalization that [s/he] wanted to leave facility.Review of the [DATE] Medication Administration Record (MAR) revealed the wanderguard order to check placement every shift was signed off inaccurately as completed on the following dates and shifts, after the resident removed his/her wanderguard: - [DATE]: 7:00 AM to 3:00 PM- [DATE]: 7:00 AM to 3:00 PM and 11:00 PM to 7:00 AM- [DATE]: 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, 11:00 PM to 7:00 AM- [DATE]: 7:00 AM to 3:00 PMFurther review of the [DATE] MAR revealed the wanderguard order to check functionality daily was signed off inaccurately as completed on the following dates, after the resident removed his/her wanderguard: 12/28, 12/29 and [DATE].During surveyor observations on [DATE] at 11:07 AM and [DATE] at 12:02 PM, a wanderguard was not noted to be on the resident's right wrist.During a surveyor interview on [DATE] at 12:07 PM, with Licensed Practical Nurse (LPN), Staff C, he acknowledged that he signed off the resident's wanderguard placement order on [DATE] in the MAR, as he had checked the resident's wrist that morning and indicated it was there.During a surveyor interview on [DATE] at 12:09 PM, with Nursing Assistant, Staff F, she revealed that the resident's wanderguard was taken by the Director of Nursing Services (DNS) on [DATE], indicating that the resident has not had it on as ordered.During a surveyor observation immediately following these interviews, in the presence of Staff C, he acknowledged that the resident did not have a wanderguard on his/her right wrist and revealed that he felt the resident's wrist that morning and what he thought was a wanderguard, was the resident's wrist bone.During a surveyor interview on [DATE] at 12:15 PM, with the DNS, she revealed that she would expect nursing staff to visualize the resident's wanderguard prior to signing off on the MAR.2. Record review revealed Resident ID #28 was admitted to the facility in December of 2025 with a diagnosis including, but not limited to, altered mental status.Record review revealed a physician order dated [DATE] for Narcan, 4 milligrams per 0.1 milliliters with instructions to administer one spray in the nostril, as needed, for opiate overdose.Record review revealed the above Narcan order was documented as being administered on [DATE] at 11:15 PM, by LPN, Staff K.Review of an order administration note dated [DATE] revealed the dose of Narcan was effective.During a surveyor interview on [DATE] at 10:22 AM, with Staff K, she revealed that Resident ID #28 was not administered Narcan, indicating that it was a documentation error.During a surveyor interview on [DATE] at 10:35 AM with the DNS, she revealed that she would expect all resident's records to be accurate.Review of a progress note dated [DATE], authored by Staff K, after this concern was brought to the facility's attention by the surveyor, states, It was bought to my attention that the narcan order was checked off that it was administered. This was in error, narcan was not administered to this resident.3. Record review revealed that Resident ID #53 was admitted to the facility in August of 2025 with diagnoses including, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but not limited to, dementia and anxiety.Record review revealed a physician's order for Seroquel 50 mg (an antipsychotic) daily in the afternoon.Review of the [DATE] Medication Administration Record revealed that on [DATE] the Seroquel was not administered as ordered. Additionally, the Seroquel was charted as - see nurses progress note.Review of the progress note dated [DATE] revealed that the Seroquel was not administered due to the resident being deceased .During a surveyor interview on [DATE] at 10:17 AM with LPN, Staff K, she acknowledged that she charted the resident was deceased although the resident was not.During a surveyor interview on [DATE] at 10:37 AM with the DNS she acknowledged that the Seroquel for Resident ID #53 was documented as not administered on [DATE] due to the resident being deceased although the resident is not. Additionally, the DNS was unable to provide evidence that Resident ID #s 2, 28, and 53 had complete and accurate medication records.