| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 415053 | A. Building<br>B. Wing | 04/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Cherry Hill Manor | 2 Cherry Hill Road<br>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 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure that a resident received timely and appropriate pain and symptom management in accordance with professional standards of practice for end-of-life care, including the prompt administration of physician-ordered medications for pain and anxiety, for 1 of 1 resident reviewed who was receiving hospice services, Resident ID #1. This failure resulted in the resident having to experience unmanaged pain, terminal agitation, and psychosocial distress during his/her final hours of life.Findings are as follows:Review of a community reported complaint submitted to the Rhode Island Department of Health on [DATE] alleged that Resident ID #1 was experiencing terminal agitation and was not provided prescribed medications promptly to provide comfort, relief, and dignity at the end of his/her life and appeared to be in pain. The complaint further alleged that Morphine (a medication prescribed to treat severe pain) had been prescribed early in the afternoon and was not administered until approximately 7:00 PM because the nurse explained she needed a code and could not administer it. Additionally, the complaint alleged that Ativan (a medication prescribed to treat anxiety) was also delayed because it needed to be delivered from the pharmacy before it could be administered. Furthermore, the complaint alleged that after speaking with the nursing supervisor at the facility, the complainant was informed that the medications were available and should have been administered promptly. According to the American Nurses Association 2025, states in part, .Nurses are responsible for recognizing patients' symptoms, taking measures within their scope of practice to administer medications, providing other measures for symptom alleviation, and collaborating with other professionals to optimize patients' comfort and families' understanding and adaptation.According to the Hospice Foundation of America's article titled, What is Hospice dated [DATE], states in part, .Hospice provides something more for patients when a cure is not an option. It is a medical care model focused on comfort. Hospice care aims to manage the patient's symptoms while supporting their quality of life. It provides support for family caregivers, too.Hospice care is provided by an interdisciplinary team of professionals trained to address the patient's medical, physical, spiritual, and psychosocial needs. The team focuses on the person, not the illness, as they coordinate patient care, clarify the goals of care, and foster communication . Record review revealed Resident ID #1 was admitted to the facility in March of 2024 with diagnoses including, but not limited to, cognitive communication deficit, chronic obstructive pulmonary disease (COPD), and chronic congestive heart failure (CHF). Review of a Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status score of 5 out of 15, indicating severe cognitive impairment. Further review revealed the resident required moderate to maximum assistance from staff for activities of daily living (ADLs).Review of a progress note dated [DATE] revealed, hospice services were discussed with the family, and an informational consult was requested in Spanish. Further review of the progress note revealed, .this writer to contact hospice agencies to advocate for that request.Record review failed to reveal evidence that the facility contacted a hospice agency to facilitate an informational consultation in Spanish, as requested, by the family on [DATE].Review of a provider note dated [DATE] states in part, HISTORY OF PRESENT ILLNESS On [DATE] member presented again with fever, increased sob [shortness of<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | breath]/hypoxia [insufficient oxygen in the body tissues], and lethargy. On call was notified and ordered stat labs, chest x-ray and to give IM [intramuscular injection] Ceftraixone [an antibiotic] and IM Lasix [a medication prescribed to assist the body in excreting excess fluids]. WBC [white blood cell count- a blood test that can measure an infection in the body] was normal at 9.0. Chest x-ray shows mild CHF. [S/he] is seen today for follow up. Was lethargic this am and unable to eat/drink/take medications safely. Was given a tylenol suppository and now more alert, can say a few words and was able to take PO [by mouth] lasix. Lung sounds with crackles throughout, has a weak non-productive cough. Discussed with [family] members [name redetected] and decision was made to refer to hospice as family would like member to be comfortable. Will increase Lasix to 40 mg [milligram] daily to aide in members comfort related to CHF. Discussed starting prn [as needed] morphine/ativan and atropine drops and [s/he] consents to medication. Referral sent to Gentiva hospice and they will be in to assess member this evening.ADVANCED CARE PLAN Member's Primary Goal of Care: Comfort; Family's Primary Goal of Care: Comfort.Record review revealed the following physician's orders:-[DATE] entered at 1:46 PM - Lorazepam Intensol [Ativan] 2 mg/milliliter [mL] - give 0.25 ml every 4 hours as needed for anxiety/agitation.-[DATE] entered at 1:53 PM - Morphine 20mg/mL - give 0.25 mL every 4 hours as needed for pain/SOB.Record review of a hospice visit note report, authored by Registered Nurse (RN), Staff A, dated [DATE] with the in-home start time of 4:05 PM, revealed the following assessment:-Vital Signs- Temperature: 102.5 (normal = 97-99 degrees Fahrenheit), Pulse 116 (normal= 60-100), Respirations 26 (normal= 16-20), Blood Pressure 150/86 (normal= approximately 120/80)-Clinical Evidence of Advancing Illness: symptoms present at rest, edema (swelling), functional decline to dependence in two or more for ADLs, worsening vital signs-Additional findings related to diagnosis: Actively dying-Other Findings: Moaning-Pain Severity: Severe-Describe Behavior: Occasional labored breathing (an intense uncomfortable effort to breathe), short period of hyperventilation (breathing faster or deeper than normal), repeated trouble calling out, loud moaning or groaning, crying, unable to console, distract or reassure.-Total pain score: 7 out of 10 (indicating severe pain)-Is current pain management effective: No, awaiting morphine from pharmacy-Sensory Perception: Very limited, cannot communicate discomfort except by moaning or restlessness-Neurologic: agitated, disoriented, lethargic, restless-Origin of Anxiety: Terminal Agitation (behaviors characterized by restlessness, confusion, and distress that can occur in the final days or hours of life that can be managed by medications)Further record review of the hospice visit note report, authored by Registered Nurse (RN), Staff A, dated [DATE] revealed, Narrative: .upon entering room, patient found to be having episodes of terminal agitation, unable to answer questions in [his/her] native language.order was written earlier today by [Nurse Practitioner, NP, Staff B] for Morphine Concentrate 5 mg [sublingual- administered under the tongue] [every] 4 [hours] as needed pain/dyspnea [shortness of breath], however med has not arrived from pharmacy. Unit Nurse [Licensed Practical Nurse (LPN) Staff C] calling to get over ride for medications needed.Record review of the [DATE] Medication Administration Record (MAR) revealed Morphine was not administered to the resident until 6:39 PM on [DATE], approximately 4 and a half hours after the medication had been ordered and approximately 2 hours after the hospice nurse had assessed the resident with the above-mentioned findings, which included severe pain.Further review revealed Lorazepam Intensol had not been administered to the resident until 10:40 PM on [DATE], approximately 9 hours after the medication had been ordered and approximately 6 and a half hours after the hospice nurse had assessed the resident with the above-mentioned findings, which included anxiety. Review of the available medications in the Omnicell (an automated system for medication administration) revealed, Morphine was available and could have been administered prior to 6:39 PM.Review of the available medications in the E-Kit ( an emergency medication kit supplied by the pharmacy for use when a medication is needed immediately and before it is delivered by the pharmacy) revealed, Lorazepam Intensol was available and could have been administered prior to 10:40 PM.During a surveyor interview on [DATE] at 8:57 AM with the complainant, the resident's (continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | family member, s/he revealed that on the afternoon of [DATE], less than 24 hours prior to the resident's death, there was a delay in providing the resident with his/her ordered Morphine and Ativan. Additionally, the family member indicated that the resident was in agonizing pain. S/he further indicated that the resident was experiencing anxiety and his/her feet were hanging off of the bed when s/he entered the resident's room.During a surveyor interview on [DATE] at 10:34 AM with LPN, Staff D, he revealed that all of the facility's nurses have access to the Omnicell and would expect that a medication would be taken from the Omincell to be administered to a resident if it was ordered for them and unavailable otherwise.During a surveyor interview on [DATE] at approximately 11:30 AM with Registered Nurse (RN), Staff E, she revealed that Ativan Intensol is available in the E-Kit that is provided by the pharmacy. She stated that the E-Kit requires two nurses to sign for the medication when removing medication from the E-Kit. She further revealed that the E-kit had not been opened recently. During a surveyor interview on [DATE] at 11:44 AM with hospice nurse, Staff A, she revealed that she arrived at the facility and assessed Resident ID #1 on [DATE] at approximately 4:00 PM. She indicated that the resident appeared to be exhibiting signs of terminal agitation at that time. She further revealed that the resident had periods of extreme anxiety and agitation during the visit and was told by LPN, Staff C, that she was waiting for the code from the pharmacy before administering Morphine to the resident. Additionally, she revealed that she would have expected the Morphine and Ativan to be administered to Resident ID #1 sooner than it had been on [DATE].During a surveyor interview on [DATE] at 11:57 AM with the Director of the Hospice Agency, she revealed that the hospice nurse arrived at the facility the same day that the referral was received from the facility, which was [DATE]. She further revealed that the agency had not received a referral for Resident ID #1 prior to [DATE].During a surveyor interview on [DATE] at approximately 12:00 PM with NP, Staff B, she revealed that the resident had a recent decline and was admitted to hospice on [DATE]. She further revealed that she prescribed Morphine and Ativan, as needed, prior to the hospice nurse coming to the facility to assess the resident. Additionally, she revealed that the administration of medications prescribed as needed is at the nurse's discretion and that if the resident was screaming or in pain, she would expect the medications to be administered.During a surveyor interview on [DATE] at 12:11 PM with LPN, Staff C, she revealed that she was the nurse who cared for Resident ID #1 on [DATE] during the 3:00 PM to 11:00 PM shift. She further revealed that the resident was sweaty, warm, and reaching out for people's hands because it was the end. Additionally, Staff C revealed that the resident had pain from arthritis, and she did not feel s/he needed the morphine, so she waited to get a code from the pharmacy to administer the Morphine from the Omnicell and administered it later in the evening. Furthermore, she indicated that she didn't think about the availability of the Lorazepam Intensol in the E-Kit. During a surveyor interview on [DATE] at approximately 1:40 PM with the Director of Nursing Services, she revealed, Resident ID #1 rapidly declined. She further indicated that the hospice nurse is not employed by the facility and the nurse employed by the facility is to assess the resident and administer medications as needed. Additionally, she could not provide evidence that Resident ID #1 received treatment and care in accordance with professional standards of practice, relative the administration of end of life medications. Due to the facility's failure to administer Morphine and Ativan in a timely manner on [DATE] despite both medications being readily available in the facility's E-Kit and Omnicell, the facility failed to ensure appropriate end-of-life care and symptom management of a hospice resident. As a result, Resident ID #1 was subjected to unnecessary and avoidable pain, unmanaged terminal agitation, and psychosocial distress during their final hours of life, constituting a serious breach in the standard of care. Further record review revealed the resident expired on [DATE] at 10:00 AM. |