| 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 | 01/08/2026 |

| 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.

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| F 0569<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.<br><br>Based on clinical record review and staff interview, the facility failed to notify each resident, or resident representative, who receives Medicaid benefits, when the amount in the resident's account reaches $200 less than the Social Security Income (SSI) resource limit for 3 of 3 residents reviewed with over $4000 in personal needs funds handled by the facility, Resident ID #s 65, 77, and 159.Findings are as follows:Record review of Title 210-Executive Office of Health and Human Services, Chapter 50-Medicaid Long-Term Services and Supports (LTSS) under section 2.4 (G) of the Uniform Accountability Procedures for Title XIX Resident Personal Needs Funds in Community Nursing Facilities, ICF/DD Facilities, and Assisted Living Residences requires that the facility shall: .(10) The nursing facility must notify the resident in writing when his/her balance reaches $200.00 less than the resource eligibility guideline, that Medicaid eligibility is jeopardized if the account exceeds the guideline [4,000] .Review of a facility document titled, Trial Balance .Balances as of 12/31/2025 for the residents reviewed, revealed the following:- Resident ID #65 has a current balance of $4,067.67.- Resident ID #77 has a current balance of $4,171.23.- Resident ID #159 has a current balance of $7,053.36.During a surveyor interview on 1/7/2026 at 10:07 AM with the Assistant Business Office Manager, Staff A, she was unable to provide evidence that the above identified residents were notified in writing when their account balances reached $200 less than the SSI Medicaid eligibility resource limit ($4,000). |

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 0577<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.<br><br>Based on surveyor observation and clinical record review, the facility failed to protect identifying information for four (4) current residents listed in a resident-identifying document located in the facility's survey results binder for 1 of 2 surveys reviewed.Findings are as follows:A surveyor observation on 1/7/2026 at approximately 12:45 PM of the first-floor lobby area revealed a black survey results binder was stored on a wall in the facility lobby, accessible to the public.Record review of the survey binder revealed a resident roster (a list provided to a facility that corresponds to a number identifier utilized in a survey to protect privacy) included with the statement of deficiencies for the following surveys:-Survey results for exit date 12/7/2023, identifying Resident ID #s 8, 46, 62 and 146.Further record review of the above survey with the attached rosters contained information including, but not limited to, physician's orders and medical diagnoses.During a surveyor interview on 12/7/2025 immediately following the above observation with the Administrator, she acknowledged that the residents' names along with their corresponding number identifiers were included in the binder and should not have been. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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 surveyor observation, clinical record review, and staff and resident interview, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice relative to 1 of 1 resident reviewed with an observed skin tear, Resident ID #7.Findings are as follows:Review of a facility policy last reviewed 8/29/2025 titled, Changes in Resident's Condition or Status states in part, .The facility will notify the resident, his/her primary care provider, and resident/resident representative of changes in the resident's condition or status.Record review revealed Resident ID #7 was admitted to the facility in February of 2025 with diagnoses including, but not limited to, hemiplegia and hemiparesis following a cerebral infarction (stroke) affecting the left side. Review of the Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 15 out of 15, indicating intact cognition. Further review revealed the resident required maximum assistance from staff for activities of daily living including personal hygiene and upper body dressing.Surveyor observations revealed the resident had an undated, white bordered gauze dressing to his/her elbow with visible dark drainage on the following dates and times:- 1/5/2026 at 12:58 PM- 1/5/2026 at 3:08 PM- 1/6/2026 at approximately 3:30 PMDuring a surveyor interview with the resident on 1/5/2026 at 12:58 PM, s/he indicated that s/he had hit his/her elbow on the arm rest of the wheelchair recently and a nurse had applied the dressing. The resident was unsure of when the dressing was first applied but stated that it was probably time for the dressing to be changed.Record review of the physician's orders, failed to reveal evidence of an order for a dressing to the left arm.Record review failed to reveal any documentation of the wound including a description, measurements, or that the provider was notified of a new skin impairment requiring a dressing.During a surveyor observation and interview on 1/7/2026 at 9:52 AM with the resident, a pink bordered foam dressing was observed to be on the resident's left elbow labeled 1/7/26 7-3. The resident indicated that the dressing had been changed that morning but had not been changed for a few days.During a surveyor interview on 1/7/2025 at approximately 10:00 AM, with Licensed Practical Nurse, Staff B, she indicated that she had worked on the unit the day before but had just been made aware of a new skin impairment to the resident's arm that morning, when there was blood everywhere. She further indicated that she applied a dressing to the resident's left arm and would be texting the Nurse Practitioner (NP) to notify her of the wound. Additionally, she acknowledged that an order was not in place for a dressing to the resident's left elbow or that were was any documentation that the wound had been identified prior to 1/7/2026. Furthermore, she indicated that she would expect the provider, family, and risk management, to be notified of a new wound and a progress note to be completed. During a surveyor interview on 1/07/2026 at 10:07 AM with the Unit Manager, Staff C, she revealed that she had just been made aware of the resident's skin impairment. She then stated, you're calling the NP right, [Staff B]? During a surveyor interview and observation on 1/7/2026 at approximately 10:30 AM, with the Assistant Director of Nursing and wound nurse, Staff D, she indicated that she had just been made aware of the wound to the resident's left arm and then measured and assessed the wound. The wound consisted of three skin tear areas collectively measuring 3 centimeters (cm) by 3 cm.During a surveyor interview on 1/7/2026 at 3:11 PM with the Director of Nursing Services, she indicated that she would expect the provider to be notified when a wound is identified. Additionally, she could not provide evidence that the provider had been notified or that an order had been given pertaining to the treatment of the wound to the resident's left arm, when it was initially identified. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure that a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 of 1 resident reviewed with a newly identified skin impairment to his/her left heel, Resident ID #80.Findings are as follows:Review of a facility policy revised on 6/11/2025, titled Skin Integrity & Ulcer/Injury Prevention, states in part, .Based on a comprehensive assessment of a resident, the facility must ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers.A skin assessment/inspection should be completed weekly by a nurse. Skin observation also occurs throughout points of care provided by CNAs [Nursing Assistants] during ADLs [activities of daily living] care. When skin breakdown occurs, it requires attention and a change in the plan of care may be indicated to treat the resident.According to the American Academy of Family Physicians 2023, .Pressure injuries are localized damage to skin or soft tissue. They commonly occur over bony prominences and often present as an intact or open wound .they significantly impact patient quality of life. Comprehensive skin assessments are crucial for evaluating pressure injuries .treatment involves pressure off-loading .deep tissue pressure injury .intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister . Stage 2 pressure injury .may also present as an intact or ruptured serum-filled blister .Record review revealed the resident was admitted to the facility in June of 2024 with diagnoses including, but not limited to, dementia and muscle weakness.Record review of a care plan dated 7/5/2025 revealed, that s/he is at risk for alteration in skin integrity due to impaired mobility with interventions including, but not limited to, assessing the location, the size, the treatment of skin injury, and to report the failure to heal to the provider. Further review of the care plan revealed the resident receives hospice services.Record review of the Minimum Data Set (MDS) assessment dated [DATE], revealed the resident is at risk for developing pressure ulcers requiring pressure reducing devices while in bed and while in a chair. Further review revealed the resident did not have any pressure ulcers or skin impairments to his/her feet at the time of the assessment. Additional review revealed the resident is dependent on staff for ADLs including dressing. Record review revealed the following physician's orders:-12/2/2025- apply skin prep to bilateral heels twice daily.-12/2/2025- apply skin prep to left heel blister then cover with a dressing every 7 days.-12/3/2025- apply heel boots every shift for boggy heels (skin tissue that feels unusually soft, spongy, or mushy, indicating excess fluid and damage beneath the surface, often a warning sign for developing a pressure injury on the heel, especially in immobile patients, and requires immediate relief and assessment. It is an early sign of a deep tissue Injury appearing a discolored area) as tolerated.During surveyor observations the resident was observed without the heel boots applied on the following dates and times: -1/6/2026 at approximately 10:00 AM while in bed. -1/6/2026 at 12:30 PM while sitting the broader chair in the common area. -1/6/2026 at 1:40 PM while in the common area. -1/7/2026 at 9:38 AM the resident was in the broader chair, being wheeled out of the room by a Nursing Assistant (NA) after AM care. -1/7/2026 at 10:22 AM in the broader chair in the common area. Record review of the resident's clinical medical record failed to reveal evidence that s/he was unable to tolerate the heel boots. Further review failed to reveal evidence of measurements or descriptions of the skin impairment to the left heel which was identified in the physician's orders on 12/2/2025. During a surveyor interview on 1/7/2026 at approximately 10:30 AM with NA, Staff E, she revealed that she was not aware that the resident requires bilateral heel boots. Additionally, Staff E indicated the resident receives hospice services, so s/he does not need heel boots. During a surveyor interview on 1/7/2026 at approximately 11:00 AM with Licensed Practical Nurse (LPN), Staff F, she indicated<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | that she failed to put the resident's heel boots on after she completed the resident's treatment to his/her left heel. Record review of the weekly skin checks failed to reveal evidence of a skin impairment to the left heel on the following dates:-12/6/2025-12/20/2025-12/27/2025-1/3/2026 During a surveyor observation of the resident's heels on 1/8/2026 at 1:27 PM, in the presence of the Assistant Director of Nursing Services (ADNS)/Wound Nurse, the resident was observed to have a non-blanchable darkened skin impairment to his/her left heel, measuring 2.4 centimeters(cm) x 2.3 cm. During a subsequent surveyor interview with the ADNS, immediately following the above observation, she acknowledged a new skin impairment that had been classified as a blister was documented in a treatment order dated 12/2/2025. She indicated that she would expect the notification of the provider to be documented in a progress note as well as the measurements of the skin impairment. Additionally, she acknowledged that she would expect skin checks to reflect skin impairments and that the impairments be described.During a surveyor interview on 1/8/2026 at approximately 2:30 PM with the resident's physician, he indicated that he would have expected the staff to document the resident's skin impairment to the left heel in his/her medical record.During a surveyor interview on 1/8/2026 at 3:07 PM with the Director of Nursing Services, in the presence of the Administrator, she was unable to provide evidence that the skin impairment identified on 12/2/2025 was documented and measured. Additionally, she was unable to provide evidence that the resident's heel boots were applied, as ordered. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>Based on clinical record review and staff interview, the facility failed to ensure residents are free from medication errors relative to 1 of 2 residents reviewed with an order for midodrine (a medication prescribed to treat low blood pressure) who received the medication outside of the ordered parameters, Resident ID #13.Findings are as follows:Record review revealed the resident was admitted to the facility in June of 2025 with diagnoses including, but not limited to, hypotension (low blood pressure) and end stage renal disease.Record review revealed a physician's order dated 12/16/2025 for Midodrine HCl oral tablet, 2.5 milligrams (mg), give 1 tablet by mouth two times a day for hypotension, hold for blood pressure (BP) greater than 130 (systolic, top number of a blood pressure reading).Record review of the December 2025 and January 2026 Medication Administration Records (MAR) revealed the midodrine was administered outside of the blood pressure parameters on the following dates and times: - 12/22/2025 at 8:00 AM, BP at 133/59 - 12/27/2025 at 8:00 AM, BP at 138/60 - 1/2/202026 at 6:00 PM, BP at 154/65During a surveyor interview with Unit Manager, Licensed Practical Nurse, Staff G, on 1/7/2026 at approximately 11:30 AM, she revealed that if the order is documented as completed in the MAR, then it was administered to the resident.During a surveyor interview with the Director of Nursing Services in the presence of the Administrator on 1/7/2026 at 2:49 PM, she was unable to provide evidence that the midodrine was held according to the blood pressure parameters on the above dates and times, as ordered. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Based on clinical record review and staff interview, the facility failed to ensure that resident records are complete and accurately documented, relative to medication administration, for 1 of 2 residents reviewed for Midodrine HCL (a medication prescribed to treat low blood pressure), Resident ID #13 and for 1 of 1 resident reviewed relative to a blister of the left heel, Resident ID #80. Findings are as follows: 1) Record review revealed Resident ID #13 was admitted to the facility in June of 2025 with a diagnosis including, but not limited to, hypotension (low blood pressure (BP)). Record review revealed a physician's order dated 12/16/2025 for Midodrine HCL 2.5 milligrams (mg) 1 tablet, two times daily for hypotension. The order states to hold the medication for blood pressure greater than 130. Record review of the January 2026 Medication Administration Record (MAR) on 1/6/2026 revealed, the Midodrine was documented as given when the patient had a blood pressure above 130 on the following dates and times: - 1/4/2026 at 6:00 PM- BP 160/75 - 1/5/2026 at 6:00 PM- BP 166/73 - 1/6/2026 at 8:00 AM- BP 144/62 During a surveyor interview on 1/7/2026 at approximately 2:45 PM with the Director of Nursing Services (DNS), and the Administrator revealed, the surveyor brought the errors to their attention. Subsequent record review of the January 2026 MAR, on 1/8/2026, revealed the Midodrine documentation was modified, and the number 3 was added indicating that the vitals were outside the parameters of administration on the following days: - 1/4/2026 at 6:00 PM - 1/5/2026 at 6:00 PM - 1/6/2026 at 8:00 AM During a surveyor interview on 1/8/2026 at approximately 2:00 PM with the DNS, she revealed that she had spoken to the nurses who administered medications on the above dates and times. She further revealed that the nurses stated that they did not administer the Midodrine, so they changed the documentation in the January 2026 MAR to reflect that the medication was not administered. 2) Record review revealed Resident ID #80 was admitted to the facility in June of 2025 with diagnoses including, but not limited to, adult failure to thrive, and abnormalities of gait and mobility. Record review revealed the following physician's orders: - Apply Skin prep to left heel and cover with a clean dry dressing every 7 days for a blister. This order was dated 12/2/2025 and was discontinued on 1/7/2026. - Skin prep to left heel followed by a foam dressing every 7 days for protection. This order was dated 1/7/2026. - Skin prep to left heel followed by a foam dressing as needed if dressing is soiled or rolls off. This order was dated 1/7/2026. Record review of a progress note dated 1/7/2026 at 6:03 PM revealed that the resident has a callous to the left lateral heel, and that there is a treatment in place.Record review of the resident's weekly skin monitoring checks failed to reveal documentation regarding impaired skin integrity to the left heel on the following dates: 12/6/2025 12/20/2025 12/27/2025 1/3/2026 Record review of the resident's Weekly Skin Integrity Data Collection, dated 12/13/2025 revealed, under section A.2., Select any alteration in skin that box 2q1. other had been checked. The description box below the selection indicated, left heel/treatment in place. Surveyor observation on 1/8/2026 at 1:27 PM in the presence of the Assistant Director of Nursing (ADNS) revealed a hardened non-blanchable (visible redness of the skin that persists even with the application of pressure) area to the resident's left heel. During the observation the ADNS described the area to be a callous. During a surveyor interview on 1/8/2026 at approximately 1:40 PM with the ADNS, she acknowledged that the area was not documented on the skin checks and revealed that she would have expected the area to be assessed and described on the skin checks. |