

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415054	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2025
NAME OF PROVIDER OR SUPPLIER South Kingstown Nursing and Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 2115 South County Trail West Kingston, RI 02892	

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)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>41542</p> <p>Based on record review and staff interview, it has been determined that the facility failed to provide appropriate treatment and services for 1 of 2 residents reviewed with an indwelling Foley catheter (a flexible tube that collects urine from the bladder and empties the urine into a drainage bag), Resident ID #3.</p> <p>Findings are as follows:</p> <p>Review of a facility reported incident received by the Rhode Island Department of Health on 4/9/2025 revealed that Resident ID #3 had a Foley catheter replaced at the facility without a physician's order.</p> <p>Review of Lippincott Nursing Procedures Manual Ninth Edition, last revised in 2023, states in part, . Indwelling Catheter Care and Removal .Indwelling Urinary Catheter Insertion .verify the practitioner's order .</p> <p>Record review revealed the resident was admitted to the facility in December of 2024 with diagnoses including, but not limited to, obstructive (a structural or functional hindrance of normal urine flow) and reflux (a condition where there is a backflow of urine into the kidney) uropathy and retention of urine.</p> <p>Review of the resident's care plan dated 3/26/2025, revealed a focus area for an indwelling urinary catheter related to his/her diagnosis of obstructive uropathy. Interventions include, but are not limited to, monitor, record, and report signs and symptoms of a urinary tract infection.</p> <p>Review of a physician's order dated 3/26/2025 indicated the use of an 18 French (Fr; refers to the measurement of the outer diameter of the catheter) Foley catheter with a 10 cubic centimeter (cc) (the amount of saline required to inflate the catheter's balloon for stability in the bladder). The order also revealed that the resident had a urology appointment scheduled for April 24, 2025, at 1:30 PM to have the Foley catheter replaced.</p> <p>(continued on next page)</p>

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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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a progress note dated 4/9/2025, authored by Registered Nurse, Staff A, states in part, Resident observed to be pulling on Foley at times overnight and resistant to redirection to not pull on it. Foley noted to have less than 100 ml (milliliter) urine output at approximately 2am, nurse attempted to flush Foley but unable to get return. Foley removed and new foley 16 fr 5 cc balloon coude tip (a urinary catheter with a curved tip designed to navigate around obstacles in the urethra, such as an enlarged prostate) catheter inserted with immediate return of more than 100 ml urine .</p> <p>This progress note indicates that Staff A replaced the resident's Foley with a Foley that is larger in diameter, has a smaller balloon to anchor it in place, and is a different style Foley than the physician's order. Additionally, the order did not indicate that the resident required a coude catheter.</p> <p>Record review failed to reveal evidence of a physician's order to change the resident's Foley catheter prior to the 4/25/2025 scheduled appointment.</p> <p>Further review of the progress note dated 4/9/2025 revealed, .During foley insertion [genitalia] noted to be slightly enlarged. Nurse provided resident with rolled towel under [genitalia] while in bed. Upon nurse-to-nurse handover [genitalia] and hematuria [blood in the urine] reassessed. [Genitalia] noted to have increased significantly in size while elevated on rolled towel. Hematuria noted to foley bag. Blood noted to urethral opening. Transfer to emergency room for evaluation initiated.</p> <p>During a surveyor interview on 4/17/2025 at approximately 8:30 AM with the Director of Nursing Services, in the presence of the Administrator, she revealed that the resident's diagnosis upon hospital admission was pyelonephritis (inflammation of the kidney usually due to a bacterial infection). She indicated that Staff A should not have changed the resident's Foley catheter, because the resident had an order in place to have it changed at the urologist's office. Additionally, she revealed that she would have expected the nurse to call the physician with her concerns, for further recommendations and orders.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>41542</p> <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that resident records are complete and accurately documented, relative to narcotic medication administration, for 3 of 6 residents reviewed, Resident ID #s 2, 4, and 5.</p> <p>Findings are as follows:</p> <p>Review of a facility reported incident submitted to the Rhode Island Department of Health on 4/9/2025 indicated that two alert and oriented residents reported they did not receive their PRN (as needed) narcotic pain medication overnight after requesting it multiple times and that there appeared to be discrepancies between the narcotic log book and the resident's Medication Administration Records (MAR).</p> <p>According to the Lippincott Nursing Procedures Ninth Edition last revised in 2023 states in part, .Safe Administration Practices .Document all medications administered in the patient's MAR or EMAR [Electronic Medication Administration Record]. Include the medication strength, dose, route of administration, and date and time of administration .</p> <p>A. Record review revealed Resident ID #2 was admitted to the facility in February of 2025 with diagnoses including, but not limited to, pain related to lumbar spinal stenosis (a condition in which the spaces in the spine narrow, compressing the spinal cord or nerves) and cognitive communication deficit.</p> <p>Record review revealed a physician's order dated 3/25/2025 for oxycodone (a narcotic medication prescribed to treat pain) 10 milligrams (mg), with instructions to administer 1 tablet every six hours, as needed.</p> <p>Review of the Narcotic Administration Log revealed documentation that the resident was administered one tablet of oxycodone, 10 mg , on 4/9/2025 at 12:30 AM, by Registered Nurse, Staff A.</p> <p>Review of Resident ID #2's April 2025 MAR failed to reveal evidence that the 4/9/2025 dose of oxycodone 10 mg, was documented as being administered to Resident ID #2.</p> <p>B. Record review revealed Resident ID #4 was admitted to the facility in April of 2025 with diagnoses including, but not limited to, spondylolisthesis (a condition that develops when one of the bones in the spine slips out of alignment).</p> <p>Record review revealed the following physician's orders dated 4/6/2025:</p> <p>- oxycodone 5 mg, with instructions to administer one tablet every six hours, as needed for severe pain (for a pain score of 8-10)</p> <p>- oxycodone 5 mg, with instructions to administer 1/2 tablet (2.5mg) every six hours as needed (for a pain score of 4-7)</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Narcotic Administration Log revealed documentation that Staff A administered oxycodone twice on 4/9/2025. Once at 12:05 AM, and then again 6:15 AM.</p> <p>Review of Resident ID #4's April 2025 MAR failed to reveal documentation that the 4/9/2025 doses of oxycodone at 12:05 AM and 6:15 AM were administered to Resident ID #4.</p> <p>C. Record review revealed Resident ID #5 was admitted to the facility in April of 2025 with diagnoses including, but not limited to encephalopathy (a disorder and/or disease of the brain that affects its normal functioning) and multiple cancerous tumors throughout the resident's body.</p> <p>Record review revealed the following physician's orders dated 4/7/2025:</p> <ul style="list-style-type: none"> - oxycodone 5 mg, with instruction to administer 1 tablet every six hours, as needed for pain (for a pain score of 5 - 8) - oxycodone 5 mg, with instructions to administer 2 tablets, every six hours, as needed for pain (for a pain score of 9 - 10). <p>Review of the Narcotic Administration Log revealed documentation that Resident ID #5 was administered two tablets of oxycodone, 5 mg, on 4/8/2025 at 10:00 PM, by Staff A.</p> <p>Review of Resident ID #5's April 2025 MAR failed to reveal documentation that the 4/8/2025 dose of oxycodone, 10 mg, was administered to Resident ID #5.</p> <p>During a surveyor interview on 4/17/2025 at approximately 9:00 AM, with the Director of Nursing Services, she acknowledged that the documentation in the Narcotic Administration Logs for Resident ID #s 2, 4, and 5, were not documented on the residents' MARs.</p>