| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 415054 | A. Building<br>B. Wing | 05/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| South Kingstown Nurs. & Rehab Ctr | 2115 South County Trail<br>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) |
|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, and staff and resident interviews, the facility failed to ensure residents remained free from abuse and neglect for 1 of 1 resident reviewed when staff refused the resident's repeated requests for toileting assistance. Specifically, the facility failed to provide necessary care and services to a continent resident, resulting in the resident being left heavily saturated in urine and forced into an incontinent episode. This failure caused actual harm, including the development of a urinary tract infection (UTI) and psychosocial harm, for Resident ID #124.Findings are as follows:Review of a facility reported incident submitted to the Rhode Island Department of Health on 4/23/2026 revealed that Resident ID #124 alleged that Nursing Assistant (NA), Staff A, refused to assist him/her to the bathroom, instead instructed him/her to void in his/her brief, and did not change him/her when requested, during third shift on 4/22/2026 into 4/23/2026. According to ElderAbuse.org, elder neglect includes, but is not limited to, the failure to provide basic assistance to [an] older person who cannot self-perform daily living tasks like bathing, feeding, dressing, or going to the bathroom. Elder neglect can cause harm such as .Hygiene-Related Health Problems.like urinary tract infections.Record review revealed Resident ID #124 was admitted to the facility on [DATE] with diagnoses including, but not limited to, spinal stenosis (the narrowing of spaces within the spine) and surgical aftercare following surgery. Further review revealed the resident was discharged home on 5/3/2026. Review of the hospital Continuity of Care Form dated 4/22/2026 revealed the following provider discharge instructions following spinal surgery:- .full weight bearing.- .Do not remove your dressing. We will remove it at your 2 week follow up appointment.call the office if the dressing becomes saturated- .You are encouraged to be up and walking.Further review of the hospital documents revealed the resident required contact guard with ambulation with his/her rolling walker and assistance with transfers.Record review of the admission progress note dated 4/23/2026 at 12:52 AM, revealed the resident was admitted to the facility on [DATE] at 4:30 PM via ambulance and was transferred into bed by ambulance staff. Further review revealed the resident is alert and oriented to person, place, and time, had a surgical dressing to his/her lower back that was clean, dry and intact, and was continent of bowel and bladder. Additional review revealed the resident could ambulate with a rolling walker and staff assistance.Record review of a care plan dated 4/22/2026 revealed safe patient handling is one person assist with gait belt and rolling walker.Record review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status score of 14 out of 15, indicating intact cognition. Further review revealed the resident is always continent of urine.Record review revealed the following nursing progress notes:-4/23/2026- the resident was able to make his/her needs known, required assist with activities of daily living (ADLS), and ambulates with assistance and a rolling walker. Further review revealed the resident was administered Valium (a medication prescribed to treat anxiety) twice for complaints of increased anxiety. Additional review revealed the surgical dressing to the resident's lower back was changed due to urine saturation and a message was left for the orthopedic surgeon.-4/24/2026 at 6:35 AM- the resident complained of urinary frequency and burning<br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 415054 | A. Building<br>B. Wing | 05/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| South Kingstown Nurs. & Rehab Ctr | 2115 South County Trail<br>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) |
|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | with urination. -4/24/2026 at 7:44 PM- the resident reports urinary frequency and burning with urination. Symptoms reported to the physician and a new order was given to obtain a urinalysis with a culture and sensitivity (UA C&S- a urine test used to diagnose urinary tract infections).-4/25/2026- the resident complains of urinary frequency and burning with urination, urine sample obtained as ordered and ready for lab pick up.-4/26/2026- the resident complains of urinary frequency and burning with urination. UA results reported to the provider. New order given for Bactrim DS (an antibiotic) twice daily for three days.-4/28/2026 at 12:34 PM - the resident's surgical dressing to his/her back was saturated with serosanguinous drainage (thin pink drainage) this morning. Dressing removed with visible redness and maceration (the softening or breakdown of skin caused by the prolonged exposure to moisture) to the incision and a copious amount of drainage observed.-4/28/2026 at 10:03 PM- call out to the orthopedic surgeon to report the redness to the surgical incision and moderate serosanguineous drainage. An appointment was scheduled for 4/29/2026.-4/29/2026 at 1:41 PM- resident out to orthopedic surgeon this morning for evaluation of surgical incision. A new order was received for a daily dressing change.During surveyor interviews on 5/8/2026 at 12:31 PM and on 5/11/2026 at 9:25 AM with Nurse Manager, Staff B, she indicated that she worked first shift on 4/23/2026 and found the resident anxious and upset that s/he was incontinent of urine on that morning since s/he was continent most of the time. She revealed that the resident reported to her that the Nursing Assistant on third shift refused to assist him/her to the bathroom which resulted in him/her being incontinent of urine. She further revealed that the surgical incision dressing was saturated with urine and required a dressing change which should not have been changed until the scheduled orthopedic follow up appointment in May. Additionally, she revealed that the resident began having urinary symptoms, was found to be positive for a UTI, and was treated with antibiotics soon after the incident. Furthermore, she revealed that nursing should review the hospital paperwork for functional status so they can communicate with the NA's who are providing care to the resident. During a surveyor interview on 5/11/2026 at 9:10 AM with the alleged perpetrator, NA, Staff A, she revealed that during third shift on 4/22/2026 into 4/23/2026 she refused to assist Resident ID #124 to the bathroom and further revealed that resident requested to be assisted into the bathroom multiple times. She indicated that she told the resident that she could not assist him/her to the bathroom because s/he had not been assessed by physical therapy yet. Additionally, she revealed she did not assist the resident with incontinence care prior to leaving the facility. During a surveyor interview on 5/11/2026 at 9:32 AM with the Director of Rehab, she revealed that she would expect nursing staff to review a resident's hospital discharge documents for the resident's transfer and ambulation status and implement those instructions until the facility's therapy staff can evaluate the newly admitted resident. During surveyor interviews on 5/8/2026 at 12:51 PM and on 5/11/2026 at 9:44 AM with the Director of Nursing Services, she revealed that Resident ID #124 was able to transfer and ambulate to the bathroom with assistance on admission. She further revealed that the resident reported that NA, Staff A refused to assist him/her to the bathroom during third shift on 4/22/2026 into 4/23/2026, did not offer him/her a bed pan, and told him/her to urinate in his/her brief. Additionally, she revealed that the resident required a dressing change to the surgical incision as it was found to be saturated in urine and that Staff A was terminated from the facility following the incident. Furthermore, she revealed that she would expect nursing staff to review the resident's hospital paperwork for transfer and ambulation status and that staff would assist the resident as needed.During a surveyor telephone interview on 5/12/2026 at 10:35 AM with Resident ID #124, s/he revealed that s/he requested to be assisted to the bathroom many times on third shift, but the staff refused to assist him/her. The resident revealed that s/he was incontinent of urine and became very upset because the staff refused to assist him/her. S/he further revealed that his/her surgical incision dressing became itchy and saturated with urine following the incontinence episode caused by the staff's refusal to assist him/her to the bathroom. Additionally, Resident ID #124 revealed that s/he was not assisted to the bathroom when necessary multiple times that night and later had to be treated for a UTI.The facility's<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 415054 | A. Building<br>B. Wing | 05/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| South Kingstown Nurs. & Rehab Ctr | 2115 South County Trail<br>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) |
|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | failure to keep the resident free from neglect resulted in psychosocial and physical harm to the resident as evidenced by the resident's increased anxiety following the incident, experiencing urinary symptoms and being diagnosed with a UTI, and requiring dressing changes and an unscheduled outpatient visit with the orthopedic surgeon to evaluate the status of the resident's surgical incision, 8 days prior to the scheduled follow up visit. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 415054 | A. Building<br>B. Wing | 05/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| South Kingstown Nurs. & Rehab Ctr | 2115 South County Trail<br>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) |
|---|---|
| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, the facility failed to provide reasonable accommodation of resident needs and preferences, for 1 of 1 resident reviewed related to not getting out of bed, Resident ID #72.Findings are as follows:Record review revealed the resident was originally admitted to the facility in February of 2025 with diagnoses including, but not limited to, chronic obstructive pulmonary disease (a lung condition that causes long-term breathing problems by limiting airflow), encephalopathy (a generalized dysfunction of the brain), and complications of colostomy (a surgical procedure that creates an opening in the abdominal wall, bringing a portion of the large intestine to the surface to allow stool to exit).Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status score of 13 out of 15, indicating the resident is cognitively intact. Further review revealed that the resident is dependent on two staff members for transfers out of bed.Additional review of the MDS Section F- Preferences for Customary Routine and Activities revealed that it was not important to the resident to participate in group activities, however, it was somewhat important to do his/her favorite activities and very important for him/her to participate in religious services or practices as well as to go outside to get fresh air when the weather is good.Record review of a care plan initiated on 2/6/2026 revealed an intervention to encourage the resident to get out of bed but to respect his/her decision to stay in bed if s/he chooses. It further indicated that the resident declines invites to group activities and to offer 1 to 1 visits by activity staff as needed.Record review of a document titled Occupational Therapy OT Discharge Summary dated 10/22/2025, revealed that the resident was out of bed for greater than 6 hours at a time with the use of a cardiac recliner, gel matrix cushion and a pillow to his/her left side to maintain upright posture.During a surveyor interview on 5/6/2026 at 9:12 AM with the resident, s/he revealed that s/he could not recall the last time s/he was out of bed and indicated that staff does not offer to get him/her out of bed. The resident further revealed that s/he was unaware if s/he had a wheelchair to use, however s/he would like to get out of bed for a change of positioning and to go outside.Record review failed to reveal evidence that the resident refuses to get out of bed. During a surveyor interview on 5/8/2026 at 12:43 PM with Nursing Assistant, Staff C, she revealed that she was unable to recall the last time the resident had been out of bed, and indicated that it had been several weeks, possibly months. During a surveyor interview on 5/8/2026 at 12:48 PM with Licensed Practical Nurse, Staff D, she revealed that she was unable to recall the last time the resident had been out of bed. Additionally, she acknowledged that there was no documentation in the record that the resident refused to get out of bed.During a surveyor interview on 5/8/2026 at 2:23 PM with Occupational Therapy Assistant, Staff E, she revealed that she had treated the resident in October of 2025, at which time s/he was getting out of bed 3 to 4 times a week for 6 or more hours a day, and that the resident had not refused treatments. She further revealed that the therapy department had not been informed of any changes in the resident's condition.During a surveyor interview on 5/8/2026 at 3:09 PM with the Activities Director, he revealed that the resident had last been out of bed to attend a social activity on 12/4/2025.During surveyor interviews with the Director of Nursing Services on 5/8/2026 at 3:02 PM and on 5/11/2026 at 9:03 AM, she revealed that it was her expectation that residents are offered and encouraged to get out of bed daily. Additionally, she revealed that Resident ID #72 frequently refuses to get out of bed, however, she was unable to provide evidence of said refusals. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 415054 | A. Building<br>B. Wing | 05/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| South Kingstown Nurs. & Rehab Ctr | 2115 South County Trail<br>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) |
|---|---|
| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on clinical record review and staff interview, the facility failed to meet professional standards of quality regarding not following physician's orders for 1 of 1 resident reviewed related to medications with heart rate (HR) parameters, Resident ID #38.Findings are as follows:Record review of a facility policy titled, Medication Administration Safety Program revealed in part, .the physician's order must be verified before the medication is given.when medication are held/refused, the MD is to be notified timely.Record review revealed the resident was admitted to the facility in March of 2026 with diagnoses including, but not limited to, cardiomyopathy (a disease effecting the heart muscle which causes the heart to have a harder time pumping blood), and atrial fibrillation (an irregular and often very rapid heart rhythm).Record review revealed the following physician's order:4/6/2026-Metoprolol tartrate 25 milligrams (mg) twice daily. The order contained instructions to hold for a heart rate below 55 beats per minute (bpm), and to notify the physician.A review of the Medication Administration Records (MAR) from April 7 through April 30, 2026, revealed the medication was held on the following dates and times with no notification of the physician:4/7/2026- 5:00 PM to 8:00 PM dose- held for a HR of 524/14/2026-7:00 AM to 11:00 AM dose- held for a HR of 574/14/2026-5:00 PM to 8:00 PM dose- held for a HR of 524/16/2026-5:00 PM to 8:00 PM dose- held no documented HR4/18/2026- 5:00 PM to 8:00 PM dose- held for a HR of 524/20/2026-7:00 AM to 11:00 AM dose- held for a HR of 504/21/2026-7:00 AM to 11:00 AM dose- held for a HR of 524/22/2026-7:00 AM to 11:00 AM dose- held for a HR of 584/23/2026-5:00 PM to 8:00 PM dose- held for a HR of 524/24/2026-5:00 PM to 8:00 PM dose- held for a HR of 494/25/2026-7:00 AM to 11:00 AM dose- held for a HR of 544/26/2026-7:00 AM to 11:00 AM dose- held for a HR of 514/27/2026-7:00 AM to 11:00 AM dose- held for a HR of 674/27/2026- 5:00 PM to 8:00 PM dose- held no documented HR4/28/2026-5:00 PM to 8:00 PM dose- held for a HR of 504/29/2026-5:00 PM to 8:00 PM dose- held for a HR of 50Review of the MAR from May 1 through May 7, 2026, revealed the medication was held on the following dates and times with no notification of the physician:5/1/2026- 5:00 PM to 8:00 PM dose- held for a HR of 535/2/2026- 5:00 PM to 8:00 PM dose-held for a HR of 545/3/2026-5:00 PM to 8:00 PM dose-held for a HR of 565/4/2026-5:00 PM to 8:00 PM dose- held no documented HR5/6/2026- 7:00 AM to 11:00AM dose-held for a HR of 52Record review of the progress notes failed to reveal that the physician was notified, per the physician's order, that the metoprolol was held on the above dates and times. The physician failed to be notified 16 out of the 19 times the medication was held in April, and 5 out of the 6 times the medication was held in May.During a surveyor interview on 5/8/2026 at approximately 12:20 PM with Licensed Practical Nurse, Staff B, she acknowledged that the order was to notify the physician if the medication was held. She was unable to find evidence in the resident's record that the physician was notified when the medication was held on the above dates and times.During a surveyor interview on 5/8/2026 at approximately 12:30 PM with the Director of Nursing services she was unable to provide evidence that the physician was notified that the metoprolol was held on the above dates and times.Cross Reference F 760 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 415054 | A. Building<br>B. Wing | 05/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| South Kingstown Nurs. & Rehab Ctr | 2115 South County Trail<br>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) |
|---|---|
| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that residents are free from significant medication errors.<br><br>Based on clinical record review and staff interview, the facility failed to ensure a resident's drug regimen is free from significant medication errors for 1 of 1 resident reviewed for medication errors due to heart rate parameters, Resident ID #38. Findings are as follows:Record review revealed the resident was admitted to the facility in March of 2026 with diagnoses including, but not limited to, cardiomyopathy (a disease effecting the heart muscle which causes the heart to have a harder time pumping blood), and atrial fibrillation (an irregular and often very rapid heart rhythm).Record review revealed the following physician's order:4/6/2026-Metoprolol tartrate 25 milligrams (mg) twice daily. The order contained instructions to hold for a heart rate below 55 beats per minute (bpm), and to notify the physician.A review of the April and May 2026, Medication Administration Records (MAR) revealed the medication was held for a heart rate above 55 bpm on the following dates and times:4/14/2026- 7:00 AM to 11:00 AM dose- held for a heart rate of 574/22/2026- 7:00 AM to 11:00 AM dose- held for a heart rate of 584/27/2026- 7:00 AM to 11:00 AM dose- held for a heart rate of 675/3/2026- 5:00 PM to 8:00 PM dose- held for a heart rate of 565/7/2026 - 5:00 PM to 8:00 PM dose- held for a heart rate of 57Further review of the April and May 2026 MARs revealed the medication was held with no documented heart rate listed on the following dates and times:4/16/2026- 5:00 PM to 8:00 PM dose4/27/2026- 5:00 PM to 8:00 PM dose5/4/2026- 5:00 PM to 8:00 PM doseDuring a surveyor interview on 5/8/2026 at approximately 12:25 PM with Licensed Practical Nurse, Staff B, she acknowledged the above doses of metoprolol were given outside the heart rate parameters.During a surveyor interview on 5/8/2026 at approximately 12:30 PM with the Director of Nursing Services, she could not provide evidence that the resident's metoprolol was administered as ordered on the above dates.Cross Reference F 658 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 415054 | A. Building<br>B. Wing | 05/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| South Kingstown Nurs. & Rehab Ctr | 2115 South County Trail<br>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) |
|---|---|
| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>Based on clinical record review and staff interview, the facility failed to ensure that the resident's formulated advance directive would be followed due to inconsistency between the signed advanced directive and the electronic medical record (EMR) for 1 of 1 resident reviewed for a change in code status, Resident ID #86.Findings are as follows:Record review revealed a signed Advanced Directive dated 4/27/2026, indicating that the resident checked Full Code, .911 will be called. All resuscitative and aggressive measure are provided and I will be transferred to the hospital.Record review revealed a physician's order for Do Not Resuscitate (DNR) with a start date of 5/27/2025. This order was not discontinued until 5/8/2026, after the surveyor brought it to the facility's attention.Record review of the resident's chart revealed that DNR was also displayed on the banner at the top of his/her medical record.During a surveyor interview on 5/8/2026 at 9:47 AM with Licensed Practical Nurse (LPN), Staff D, after reviewing the resident's EMR banner and the physician's order, she stated that the resident's code status was DNR. This indicates that resuscitative measures would not be provided to the resident. During a surveyor interview on 5/8/2026 at 9:49 AM with LPN, Staff B, she revealed that she would look at the EMR to discover a resident's code status. She revealed that this resident is listed as DNR in the computer. She acknowledged after looking at the advance directive with the surveyor that the resident updated his/her code status to full code on 4/27/2026, however, it had not been updated in the EMR. During a surveyor interview on 5/8/2026 at 9:58 AM with the Director of Nursing Services, she revealed that she would expect the code status order to have been updated to match the resident's advance directive. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 415054 | A. Building<br>B. Wing | 05/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| South Kingstown Nurs. & Rehab Ctr | 2115 South County Trail<br>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) |
|---|---|
| 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>Based on clinical record review and staff interview, the facility failed to ensure that a resident receives care, consistent with professional standards of practice to prevent pressure ulcers (localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure) for 1 of 2 residents reviewed with pressure ulcers, Resident ID #3.Findings are as follows:Record review revealed the resident was readmitted to the facility in March of 2026 with a diagnosis including, but not limited to, dementia.Review of a care plan focus area initiated on 3/3/2026 revealed the resident was admitted to the facility with pressure injuries to his/her left ankle and foot. An intervention includes, but is not limited to, monitor and treat areas to left ankle and foot, as ordered.Record review revealed a document titled, Skin Ulcer Documentation, dated 5/5/2026 which revealed the resident has a stage III pressure ulcer (full-thickness skin loss potentially extending into the subcutaneous tissue layer) on his/her left lateral foot.Review of a document titled, Extended Wound Care Service Line Procedure / Progress Note, dated 5/5/2026 revealed the resident was seen by the wound provider, Nurse Practitioner, Staff F, with an order for the resident's left lateral foot wound, which states, paint with betadine [an antiseptic solution].Record review revealed a progress note dated 5/5/2026, authored by Registered Nurse (RN), Staff G, which states, Wound nurse in for treatment to left ankle/foot. New order per wound nurse to apply iodine to left lateral foot. Order reviewed and approved by MD [Medical Doctor].Record review revealed a physician's order, with a start date of 5/7/2026 which revealed to wash the left lateral foot wound with wound cleaner, pat dry, apply calcium alginate (wound treatment), followed by zetuvit bordered dressing (an adhesive bordered dressing).Review of the May 2026 Treatment Administration Record revealed the above order was signed off as completed on 5/7/2026.During a surveyor interview on 5/8/2026 at 11:45 AM, with Staff F, she revealed that her recommendation on 5/5/2026 for the resident's left lateral foot wound was to paint the wound with betadine and leave it open to air, indicating she changed the treatment to dry out the wound.During a surveyor interview on 5/8/2026 at 11:51 AM, with Staff G, she revealed that Staff F verbally told her about the new recommendation for the resident's left lateral foot. She revealed that she was provided the Extended Wound Care Service Line Procedure / Progress Note on 5/5/2026 but indicated that she did not confirm the verbal recommendation with the written recommendation on the form because it was hard to read the providers handwriting.During a surveyor interview on 5/8/2026 at 12:02 PM, with RN, Staff H, she revealed that she transcribed the incorrect order for the resident's left lateral foot and acknowledged the order should have been to paint the wound with betadine and leave it open to air, based on the recommendation provided by Staff F.During a surveyor interview on 5/8/2026 at 12:17 PM, with the Director of Nursing Services, she revealed that she would expect staff to repeat the order back to the provider or call the provider if the recommendation needed to be clarified. |