STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415061	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Health Center	4000 Post Road Warwick, RI 02886

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure that all alleged violations involving neglect are reported immediately, but not later than 2 hours to the State Survey Agency in accordance with State law for 1 of 1 resident reviewed related to being left on a bedpan for an undetermined length of time, which resulted in worsening of and the development of a new pressure ulcer, Resident ID #3.Findings are as follows:Record review of a community reported complaint submitted to the Rhode Island Department of Health on 4/6/2026, states in part, .This patient.was left on the bedpan and was injured.Review of the facility policy titled. Abuse prohibition states in part, .Neglect = failure to provide goods and/or services necessary to avoid physical harm.Any instance of actual or suspected.neglect.including injuries of unknown origins including bruises, skin tears, or lacerations must be reported immediately to the DNS (Director of Nursing Services).The Department of Health.will be contacted of allegations of.neglect.within 2 hours of the allegation if the events that led to the allegation.result in serious bodily injury.It is the responsibility of the Nursing Home Administrator to.submit the report of the allegations and the results of the internal investigation to the department of Health within 5 working days of the original filing.Record review revealed the resident was admitted to the facility in March of 2026 with a diagnosis including, but not limited to, an unstageable pressure ulcer (an unstageable pressure ulcer is a full thickness wound which is caused by prolonged pressure over a bony prominence, where the depth and extent of the tissue damage cannot be determined because the wound bed is obscured by dead tissue, slough or eschar) of the sacrum (a triangular bone at the base of the spine that connects the spinal column to the pelvis).Review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 10 of 15 indicating s/he had moderate cognitive impairment. It further revealed that the resident is dependent on staff for toileting and rolling from side to side.Record review of the wound care physician's documentation dated 3/17/2026, revealed that the resident had a pressure ulcer to his/her sacrum measuring 4 centimeters (cm) by 4.2 cm by 0.1 cm along with a surgical incision to the spine which measured 43 cm. Record review of a progress note written by the Nurse Practitioner, Staff C, on 3/23/2026 at 9:45 AM revealed in part, .seen today for a newly identified area of skin breakdown over the coccyx area. On examination there is a crescent shaped area along the coccygeal region (the anatomical area surrounding the coccyx) measuring approximately 8 cm in length and 2 cm in width. The area shows purple nonblanchable (skin redness that does not fade when pressure is applied, indicating tissue damage or compromised blood flow) discoloration with a loss of skin integrity.Onset is new since prior documented skin assessment. Findings are concerning for a pressure related injury.Record review of wound care physician documentation dated 3/24/2026 states in part, .Incident occurred where [patient] was on bedpan extended period of time: worsened unstageable sacrum wound and caused a [pressure ulcer] on [right] thigh. The documentation further revealed that the pressure ulcer to the sacrum measured 10.5 cm by 11 cm by 0.1 cm and that the resident had a new stage 3 pressure ulcer (a stage 3 pressure ulcer is a full thickness skin injury that extends into the subcutaneous fat but does not expose muscle, tendon or bone) to the right thigh (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	measuring 1.5 cm by 3.5 cm x 0.1 cm.During a surveyor interview on 4/21/2026 at 2:57 PM with the Director of Nursing Services, she acknowledged that the worsened pressure area was due to the resident being left on the bed pan for an undetermined length of time. She was unable to provide evidence that the incident involving neglect, related to leaving this resident on the bedpan for an undetermined amount of time, resulting in his/her pressure areas worsening, was reported immediately, but not later than 2 hours to the State Survey Agency in accordance with State law.Cross reference F686

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, and staff interviews, the facility failed to provide necessary treatment and services, consistent with professional standards of practice, to promote wound healing and prevent pressure ulcers for 1 of 1 resident reviewed, Resident ID #3. Specifically, the resident was left on a bedpan for an undetermined length of time, resulting in prolonged, unrelieved pressure and the worsening of an existing pressure ulcer, as well as the development of a new pressure ulcer. Findings are as follows:Record review of a community reported complaint submitted to the Rhode Island Department of Health on 4/6/2026, states in part, .This patient.was left on the bedpan and was injured.Record review revealed the resident was admitted to the facility in March of 2026 with a diagnosis including, but not limited to, an unstageable pressure ulcer (an unstageable pressure ulcer is a full thickness wound which is caused by prolonged pressure over a bony prominence, where the depth and extent of the tissue damage cannot be determined because the wound bed is obscured by dead tissue, slough or eschar) of the sacrum (triangular bone at the base of the spine that connects the spinal column to the pelvis).Review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 10 out of 15 indicating s/he had moderate cognitive impairment. It further revealed that the resident is dependent on staff for toileting and rolling from side to side.Record review of the wound care physician's documentation dated 3/17/2026, revealed that the resident had a pressure ulcer to his/her sacrum measuring 4 centimeters (cm) by 4.2 cm by 0.1 cm along with a surgical incision to the spine which measured 43 cm. During a surveyor interview on 4/21/2026 at 2:07 PM with Registered Nurse, Staff A, she revealed that the resident was admitted to the facility with a pressure area to his/her sacrum. She further revealed that the day the worsened pressure area was discovered the Nursing Assistant (NA), Staff B, told her that she found the resident lying on a bed pan, but she was unable to tell her how long the resident had been lying on the bed pan. Additionally, she indicated that the resident was noted with a new large nonblanchable area (skin redness that does not fade when pressure is applied, indicating tissue damage or compromised blood flow), which later developed into an open wound.Record review of a written statement by Nursing Assistant, Staff, B, revealed that she arrived for her shift at 7:20 AM on 3/21/2026, and that she went to offer care to the resident at 9:30 AM, 10:20 AM, and 11:30 AM but the resident declined. The statement further indicated that while she was providing care to the resident at 2:00 PM, she took the sheet off the resident, rolled him/her and realized that the resident was lying on a bedpan. Additionally, Staff B, indicated that at no time during that shift had anyone told her that the resident was assisted onto the bedpan.Record review of a progress note written by the Nurse Practitioner, Staff C on 3/23/2026 at 9:45 AM revealed in part, .seen today for a newly identified area of skin breakdown over the coccyx area. On examination there is a crescent shaped area along the coccygeal region (the anatomical area surrounding the coccyx) measuring approximately 8 cm in length and 2 cm in width. The area shows purple nonblanchable discoloration with a loss of skin integrity. Onset is new since prior documented skin assessment.Findings are concerning for a pressure related injury.Record review of the wound care physician's documentation dated 3/24/2026 states in part .Incident occurred where [resident] was on bedpan extended period of time: worsened unstageable sacrum wound and caused a [pressure ulcer] on [right] thigh. The documentation further revealed that the pressure ulcer to the sacrum now measured 10.5 cm by 11 cm by 0.1 cm, which was an increase from the wound measurements on 3/17/2026. It further revealed that the resident had a new stage 3 pressure ulcer (a stage 3 pressure ulcer is a full thickness skin injury that extends into the subcutaneous fat but does not expose muscle, tendon or bone) to the right thigh measuring 1.5 cm by 3.5 cm x 0.1 cm.During a surveyor interview on 4/21/2026 at 11:00AM with the wound care Physician, she revealed that when she assessed the wound after she was notified of an incident with the bed pan, there was a crescent (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	shaped wound that extended from the initial sacral wound. She further indicated that this crescent shaped wound appeared to follow the line of a bed pan.During a surveyor observation of the resident's wounds on 4/21/2026 at 11:45 AM in the presence of the wound care Physician's Assistant, the sacrum pressure ulcer was measured as 11.2 cm by 8.5 cm by 1 cm. The right thigh pressure ulcer was measured as 1.1 cm by 2.6 cm by 0.1 cm.During a surveyor interview on 4/21/2026 at 2:57 PM with the Director of Nursing Services, she acknowledged that she could not determine the length of time that the resident was left lying on the bed pan. Additionally, she acknowledged that the resident's pressure areas had deteriorated after the resident was found lying on the bed pan for an undetermined length of time.The facility's failure to ensure the timely removal of Resident ID #3, who is dependent on staff for assistance with toileting and has an existing pressure wound, from a bedpan and the failure to provide appropriate monitoring and repositioning, resulted in the resident being left on a bedpan for an undetermined period of time. This failure resulted in actual harm, as evidenced by the worsening of an existing pressure ulcer and the development of a new pressure ulcer. Cross reference F609