

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/11/2026
NAME OF PROVIDER OR SUPPLIER Pawtucket Falls Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 70 Gill Ave Pawtucket, RI 02861	
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 0791 Level of Harm - Actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on surveyor observation, clinical record review, and resident and staff interview, the facility failed to provide or obtain from an outside resource, emergency dental services for 2 of 2 residents reviewed, who were experiencing mouth pain, Resident ID #s 13 and 77. Findings are as follows:1. Record review revealed Resident ID #13 was admitted to the facility in January of 2025 with diagnoses including, but not limited to, diabetes and major depression. Record review revealed the following physician's orders:- 7/30/2025: Regular texture diet with thin liquids- 4/9/2026: Dentist referral for the left front lower teeth.- 4/10/2026: Orajel Toothache & Gum Gel every six hours as needed. Record review of a nursing progress note dated 4/9/2026 revealed that the resident complained of a tooth ache. The provider was in to assess the resident and ordered a referral to a dentist. Record review failed to reveal evidence that a dental consultation was obtained or that the facility attempted to obtain a dental appointment for the resident. During a surveyor interview on 5/7/2026 at approximately 1:30 PM with the resident s/he revealed that s/he has had mouth pain and has been receiving medication for approximately one month but would like to go to a dentist to have his/her tooth pulled. Additionally, s/he revealed that this was discussed with his/her provider and s/he is waiting for an appointment. During a surveyor observation on 5/8/2026 at approximately 9:30 AM of the resident's oral cavity his/her teeth were observed to be dark and discolored with a buildup of plaque. Additionally, his/her gums appeared to be swollen and red. During surveyor interviews on 5/8/2026 at 9:57 AM and 5/11/2026 at 1:30 PM with the Director of Nursing Services, she revealed that it would be her expectation that a dental appointment would be made as soon as possible for a resident who is experiencing mouth pain. She further revealed that the facility obtained a dental appointment for the resident on 5/11/2026, after the concern was brought to the facility's attention by the surveyor. 2. Record review revealed Resident ID #77 was readmitted to the facility in April of 2022 with a diagnosis including, but not limited to, diabetes mellitus. During a surveyor interview with the resident on 5/6/2026 at approximately 9:00 AM, s/he stated his/her mouth was so painful to the touch and that the pain had been going on for a while. Record review of a document titled Health Drive Dental Group dated 3/2/2026 revealed, the resident required an extraction and an evaluation by an outside oral surgeon if pain or swelling occurs. Record review of a provider order and a corresponding nursing progress note dated 4/7/2026 revealed an order for an oral surgeon consultation related to needing an extraction due to complaints of gum and mouth pain. Further record review failed to reveal evidence that the facility scheduled an appointment for an evaluation with an oral surgeon. During a surveyor interview on 5/7/2026 at approximately 12:00 PM with the Nurse Practitioner, Staff K, she acknowledged that she had approved the recommendation for the oral surgeon, but she was not aware if it was completed. During a surveyor interview on 5/7/2026 at approximately 1:30 PM with the DNS, she stated that she was unaware of the recommendation for the oral surgeon consult for Resident ID #77. Additionally, she stated that she would expect the staff to forward such recommendations to the (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 0791 Level of Harm - Actual harm Residents Affected - Few	transport coordinator to ensure appointments are arranged. During a surveyor interview on 5/7/2026 at approximately 2:00 PM with the Transportation Coordinator, she revealed that an appointment has been scheduled after it was brought to her attention that an appointment was never made. The facility's failure to secure timely dental and oral surgeon consultations for these residents represents a serious breakdown in the provision of necessary care and services. As a result, both residents endured unnecessary pain, unresolved dental conditions, and delays in clinically indicated treatment. The facility's inaction placed the residents at increased risk for worsening oral deterioration, infection, compromised nutritional status, and further decline in overall health and well-being.		

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on record review and staff interview, the facility failed to ensure that each resident was given a written accounting of his/her deposits, withdrawals, and balances, at least quarterly for 5 of 5 residents reviewed, Resident ID #s 21, 81, 85, 103, and 131. Findings are as follows: Review of a facility document titled, Trial Balance dated 5/7/2026 revealed that the facility holds funds for Resident ID #s 21, 81, 85, 103, and 131. Record review failed to reveal evidence that quarterly statements were provided to the residents or their representatives. During a surveyor interview on 5/7/2026 at 10:02 AM, with the Business Office Manager, he revealed that he was unaware that the facility must provide individual accounting of the residents' financial records through quarterly statements.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, and staff interview, the facility failed to provide services that meet professional standards of quality relative to 1 of 1 resident reviewed with an arterial wound (a skin injury caused by poor blood flow), Resident ID #30. Additionally, the facility failed to follow the physician's orders for 1 of 1 resident reviewed with an order to obtain a T4 laboratory test (a blood test that measures the levels of the hormone produced by the thyroid gland) for Resident ID #74, and for 1 of 1 resident reviewed for Thrombo-Embolic Deterrent (TED) stockings (a compression sock used to prevent blood clots in immobile, bedridden, or post-surgical patients), Resident ID #142. Findings are as follows: According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states in part, The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe that the orders are in error or would harm the clients. 1. Record review revealed Resident ID #30 was admitted to the facility in March of 2026 with a diagnosis including, but not limited to, congestive heart failure (a condition in which the heart muscle is too weak to pump, causing back flow of blood into the lungs and other tissues). Review of a physician's order revealed a treatment initiated on 4/28/2026 to cleanse the right foot second toe ulcer with normal saline, apply skin prep (a protective liquid applied to the skin that forms a barrier), and leave open to air. Record review revealed a wound care specialist began following the resident for his/her toe ulcer, and s/he was first evaluated on 5/1/2026. Review of a wound care document dated 5/1/2026 revealed the wound care specialist made recommendations to change the frequency of the skin prep wound treatment from daily to twice daily. Record review failed to reveal evidence that the wound care specialist's recommendation was addressed until after it was brought to the facility's attention by the surveyor on 5/6/2026. Further record review revealed a physician's order was initiated on 5/6/2026 to apply skin prep to the resident's right foot second toe ulcer, twice daily. During a surveyor interview on 5/7/2026 at 1:22 PM with the resident's physician, he revealed that he would expect the facility to follow the wound specialist's recommendations for wound care. During a surveyor interview on 5/7/2026 at approximately 1:35 PM with the Director of Nursing Services (DNS), she stated that she would expect the wound specialist's recommendations to be addressed immediately. 2. Record revealed Resident ID #74 was admitted to the facility in March of 2026 with a diagnosis including, but not limited to, hypothyroidism (a condition in which the thyroid gland fails to produce enough hormones to meet the body's needs). Record review of the physician's notes revealed an entry dated 3/26/2026 to check the free T4 the following day. Review of the laboratory reports failed to reveal evidence that the free T4 laboratory test had been completed, as ordered, until it was brought to the facility's attention by the surveyor on 5/7/2026. Review of the laboratory results dated [DATE] revealed an elevated T4 level of 2.7 nanograms per deciliter (ng/dL), exceeding the normal reference range of 0.8-1.9 ng/dL. Record review of the progress notes dated 5/8/2026 revealed that the provider decreased the resident's Levothyroxine (a medication prescribed to treat low thyroid hormone levels) from 150 microgram (mcg) to 125 mcg daily, as a result of the elevated T4 level obtained on 5/8/2026. During a surveyor interview on 5/11/2026 at 12:19 PM with the DNS, she stated that she would have expected the T4 laboratory testing to have been completed on 3/27/2026, as indicated in the provider's progress notes. 3. Record revealed Resident ID #142 was admitted to the facility in July of 2024 with a diagnosis including, but not limited to, nondisplaced fracture of the lateral condyle of right tibia (a crack or break on the outer, upper portion of the right shinbone at the knee joint). Record review of the physician's orders dated 5/24/2025 revealed, TED (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stockings to be applied in the morning and removed during the evening. Surveyor observations on the following dates and times, Resident ID #142 was observed not wearing the TED stockings as ordered:- 5/5/2026 at 11:08 AM and 11:14 AM- 5/6/2026 at 12:10 PM- 5/8/2026 at 10:18 AM and at 11:00 AM During a surveyor interview on 5/8/2026 at 11:03 AM with Nursing Assistant, Staff I, she acknowledged that she had provided care to the resident on 5/5/2026, 5/6/2026 and 5/8/2026, and did not put the TED stockings on the resident, as ordered. During a surveyor interview on 5/8/2026 at 11:13 AM with the Assistant Director of Nursing, she was unable to provide evidence that the resident's order for the TED stocking was being followed, as ordered. Cross reference F 842		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, and resident and staff interviews, the facility failed to provide necessary services to residents who are unable to carry out activities of daily living (ADLs) relative to scheduled showers for 2 of 2 residents reviewed who did not receive their scheduled weekly showers on 5/8/2026, Resident ID #s 3 and 122, and for 1 of 1 resident reviewed for nail care, Resident ID #8. Findings are as follows: Review of a facility policy titled Activities of Daily Living states in part, .A resident who is unable to carry out activities of daily living (ADL) will receive necessary services to maintain .grooming and personal hygiene .1. Record review revealed Resident ID #122 was readmitted to the facility in June of 2024 with diagnoses including, but not limited to, morbid obesity (a chronic disease defined by a body mass higher than 40) and urinary incontinence (the involuntary loss or leakage of urine due to an inability to control bladder function). Record review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 out of 15, indicating the resident's cognition is intact. The MDS assessment revealed that the resident is dependent on staff for toileting and requires extensive assistance for bathing/hygiene and dressing and that the resident is always incontinent of bowel and bladder. Further review of the MDS revealed that the resident's preference to receive shower is very important. Record review of a document titled Assignment for Aides 7-3, Assignment 3 revealed, the resident is scheduled to receive showers twice weekly on Tuesday and Friday. Review of the document titled Task: ADL - Shower/Bathing revealed, the resident is scheduled to receive showers twice weekly on the 7:00 AM to 3:00 PM shift. Review of shower documentation for the previous 30 days revealed the resident received only one documented shower on 4/23/2026. Further review revealed the resident missed seven scheduled showers during this time period. During a surveyor observation on 5/5/2026 at 11:40 AM, the resident was observed in bed with greasy hair. During an interview conducted at that time, the resident stated showers were not being provided as scheduled and reported that the staff frequently state there is not enough staff to provide showers. During a surveyor observation and interview with the resident on 5/8/2026 at 11:36 AM, the resident was observed lying in bed and stated that s/he had not yet received morning care. The resident further stated that s/he had experienced a bowel movement approximately one hour earlier and was uncomfortable lying in his/her feces. The resident reported activating the call light at the time of the bowel movement; however, staff did not respond. Additionally, the resident stated that s/he was scheduled to receive a shower that day but was informed by staff that the shower could not be provided due to staffing shortages. During a surveyor interview on 5/8/2026 at approximately 12:00 PM with the resident, in the presence of the Director of Nursing Services (DNS), the resident reiterated the above concerns. At that time, the resident had received a bed bath and incontinent care but had not received the preferred scheduled shower. During this interview, Nursing Assistants (NA), Staff L and M who were in the resident's room stated that they were unable to provide the resident with his/her scheduled shower due to insufficient aides assigned on the unit. 2. Record review revealed Resident #3 was admitted to the facility in May of 2024 with diagnoses including but not limited to, type 2 diabetes mellitus, and anxiety disorder. Record review of Quarterly MDS assessment dated [DATE] revealed a BIMS score of 8 out of 15, indicating the resident's cognition is moderately impaired, that the resident is dependent on staff for transfers, requires extensive assistance for bathing/hygiene and dressing, and that the resident is always incontinent of bowel and bladder. Further review of the MDS revealed that the resident's preference to receive showers is very (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	important. Review of the care plan last revised on 9/19/2025, identified the resident as dependent on staff for physical and social needs related to impaired mobility and change in health status, with interventions to provide required physical care throughout the resident's stay. Record review of the document titled, Assignment for Aides 7-3, Assignment 1 revealed, the resident was scheduled to receive showers twice weekly on Monday and Friday. Review of the document titled Task: ADL - shower/bathing revealed, the resident was scheduled for showers twice weekly on the 7:00 AM-3:00 PM shift. This documentation indicated only one shower was provided on 5/1/2026 within the previous 30 days, indicating the resident missed seven scheduled showers in 30 days. During a surveyor observation and interview on 5/8/2026 at 12:11 PM, the resident was observed up, dressed, and sitting in the Geri-chair. S/he stated that s/he had not received his/her scheduled shower for that day. During a surveyor interview on 5/8/2026 at 12:15 PM with NA, Staff L, she acknowledged that the resident had not received his/her scheduled shower prior to ADL care on this date. During a surveyor interview on 5/8/2026 at approximately 1:00 PM with the DNS, she indicated that she would expect the staff to provide showers as scheduled. 3. Record review revealed Resident ID #8 was admitted to the facility in November of 2024 with diagnoses including, but not limited to, hemiplegia (a form of paralysis that affects only one side of the body) and hemiparesis (weakness on one side of the body) to the left side. Record review of a Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, indicating the resident's cognition is intact. Additionally, the assessment revealed the resident requires substantial to maximum staff assistance with personal hygiene and grooming. Record review of a care plan dated 3/26/2025 revealed, the resident has self-care performance deficits related to decreased mobility and a history of a stroke requiring staff to assist with ADLs. Staff interventions include, but are not limited to, check nail length, trim and clean on bath days, and as necessary. During a surveyor interview and observation on 5/6/2026 at 11:45 AM, the resident's left-hand fingernails were observed to be approximately 1/2 inch in length. The resident stated that s/he would like his/her fingernails trimmed but is unable to do so independently. During a surveyor observation on 5/7/2026 at 9:06 AM, in the presence of Unit Manager, Staff N, she acknowledged the resident's fingernails were long and needed to be trimmed. During a surveyor interview on 5/7/2026 at 12:49 PM with the DNS, she was unable to provide evidence that Resident ID #8 had received assistance with nail care, as required. Cross Reference F 725		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on clinical record review and staff interview, the facility failed to ensure that irregularities identified by the Consultant Pharmacist during the monthly Medication Regimen Review (MRR) were acted upon for 3 of 3 residents reviewed with outstanding pharmacy recommendations related to medication monitoring, Resident ID #s 10, 43, and 48. Findings are as follows: 1. Record review revealed that Resident ID #10 was admitted to the facility in February of 2026 with a diagnosis including, but not limited to, dementia. Record review revealed a pharmacy MRR document titled, NURSING RECOMMENDATIONS/NURSE MANAGER REPORT dated 2/13/2026, revealed the following recommendation for his/her high-risk medication monitoring:- Furosemide (a diuretic medication that is prescribed to remove excess fluid in the body), monitor for signs and symptoms of dehydration, electrolytes, acute kidney injury, monitor for edema (swelling), congestion, and weight changes. Record review failed to reveal evidence that the above-mentioned medication monitoring recommendation was implemented. During a surveyor interview on 5/8/2026 at approximately 11:30 AM with the Director of Nursing Services (DNS), she was unable to provide evidence that Resident ID #10's pharmacy MRR recommendation was acted upon by the provider until after it was brought to the facility's attention by the surveyor. 2. Record review revealed Resident ID #43 was admitted to the facility in October of 2025 with diagnoses including, but not limited to, major depressive disorder and anxiety. Record review revealed a pharmacy MRR document titled, NURSING RECOMMENDATIONS/NURSE MANAGER REPORT dated 3/13/2026, revealed the following recommendations for his/her high-risk medication monitoring:- Hydrochlorothiazide (a diuretic medication), monitor for signs and symptoms of dehydration, electrolytes, acute kidney injury, monitor for edema, congestion, weight changes - Gabapentin (an anticonvulsant medication), monitor for signs of seizures, pain assessment, changes in behaviors, therapeutic drug levels, rash, fever and dizziness. Record review failed to reveal evidence that the above-mentioned medication monitoring recommendations were implemented until after it was brought to the facility's attention on 5/7/2026, when the surveyor had requested to review the resident's pharmacy MRR document, that the provider signed in agreement with the above-mentioned recommendations. During a surveyor interview on 5/8/2026 at approximately 11:30 AM with the DNS, she was unable to provide evidence that Resident ID #43's pharmacy MRR recommendations were acted upon by the provider until after it was brought to the facility's attention by the surveyor. 3. Record review revealed Resident ID #48 was admitted to the facility in July of 2025 with a diagnosis including, but not limited to, dementia. Record review revealed a pharmacy MRR document titled, NURSING RECOMMENDATIONS/NURSE MANAGER REPORT dated 3/13/2026, revealed the following medication recommendations:- Bisphosphonate (a medication prescribed to strengthen bones), is to be administered in the morning with a full glass of water (6-8 ounces) at least 30 minutes before the first food, beverage, or medication. To avoid esophageal (throat) irritation, patients should not lie down for at least 30 minutes post dose- The resident has an order to crush medications, and the above medication cannot be crushed, and to review with a provider for an alternative. Record review failed to reveal evidence that the above-mentioned recommendations were implemented. During a surveyor interview on 5/8/2026 at approximately 11:30 AM with the DNS, she was unable to provide evidence that Resident ID #48's pharmacy MRR recommendations were acted upon by the provider until after it was brought to the facility's attention by the surveyor. During a surveyor interview on 5/11/2026 at 12:19 PM with the Administrator in the presence of the DNS, he revealed that he would have expected the (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	above-mentioned pharmacy recommendations to have been addressed immediately. Cross reference F 760 and F 757		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure a resident's drug regimen is free from unnecessary drugs for 2 of 2 residents reviewed with medication recommendations identified by the Consultant Pharmacist during the monthly Medication Regimen Review (MRR), Resident ID #s 75 and 111. Findings are as follows: 1. Record review revealed Resident ID #75 was admitted to the facility in March of 2026 with a diagnosis including, but not limited to, history of nicotine dependence. Record review revealed a document titled, New Admission/re-admission Review, dated 3/24/2026, with a recommendation to continue the nicotine patch daily for two weeks and then discontinue. Further review of this document revealed that the physician agreed to continue the nicotine patch daily for two weeks and then discontinue. Additionally, it revealed a handwritten note that states, RB [Initials] may d/c [discontinue] per [physician] 3/24/26. Review of the April 2026 Medication Administration Record revealed that the resident's nicotine patch was not discontinued after the two-week period, resulting in the resident receiving four additional administrations of the nicotine patch. During a surveyor interview on 5/11/2026 at 12:46 PM with the Assistant Director of Nursing Services, she acknowledged that she initialed the pharmacy recommendation on 3/24/2026 but was unable to provide evidence the nicotine patch order was discontinued after the two-week time period, as ordered by the physician. 2. Record review revealed Resident ID #111 was readmitted to the facility in January of 2026 with diagnoses including, but not limited to, vertigo (dizziness) and anxiety. Record review of a hospital Discharge summary dated [DATE], revealed an order for Meclizine (a medication prescribed to treat dizziness) 12.5 milligrams (mg) two times a day, as needed for dizziness. Record review revealed a document titled, New Admission/re-admission Review, dated 2/12/2026, indicates to review the Meclizine as it was entered incorrectly as standing and should have been entered as needed. Record review revealed a physician's order dated 1/13/2026 for Meclizine 12.5 mg two times daily. Further record review revealed that the resident has received this medication two times daily since 1/13/2026. Record review failed to reveal evidence that the New Admission/ re-admission Review completed by the Consultant Pharmacist on 2/12/2026 was addressed by the facility. During a surveyor interview on 5/8/2026 at approximately 11:30 AM with the Director of Nursing Services, she was unable to provide evidence that the recommendation for Resident ID #111 was acted upon until after it was brought to the facility's attention by the surveyor.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure that residents are free from any significant medication errors for 3 of 3 residents reviewed for significant medication irregularities identified by the Consultant Pharmacist during the Medication Regimen Review (MRR), including the omission of an antibiotic and the failure to discontinue insulin for Resident ID #48, for a change in medication to manage excess fluids for Resident ID #70, and for an inhaler to manage a chronic lung disease for Resident ID #111. Additionally, the facility failed to ensure that residents are kept free from any significant medication errors for 1 of 1 resident reviewed for vascepa (a medication prescribed for cardiovascular health) and stiolto respimat (an inhaled medication prescribed to treat chronic obstructive pulmonary disease, COPD), Resident ID #73. Findings are as follows: 1. Record review revealed Resident ID #48 was readmitted to the facility in April of 2026 with diagnoses including, but not limited to, dementia and type II diabetes mellitus. Record review revealed the resident was readmitted to the facility following a brief hospitalization for acute cystitis (bladder infection) on 4/10/2026. Review of a pharmacy MRR document titled, New Admission/re-admission Review dated 4/16/2026, revealed the following significant medication recommendations that required attention:- Insulin glargine (a long-acting insulin) was indicated on the hospital continuity of care (COC) form to be discontinued, however the resident continued to receive it.- Cefpodoxime (an antibiotic) 100 milligrams (mg) was ordered on the hospital COC to be administered twice daily, and to clarify the order and determine an appropriate end date, however, the resident was not currently receiving it. Record review failed to reveal evidence that the above-mentioned pharmacy recommendations were addressed by the facility. Review of the hospital COC form dated 4/10/2026 revealed for the resident to start taking cefpodoxime 100 mg every 12 hours and to discontinue his/her insulin glargine. Review of a progress note dated 4/10/2026 at 11:43 PM revealed that a provider had reviewed and approved the resident's medication list. Record review failed to reveal evidence that the resident received cefpodoxime following his/her readmission to the facility after the provider had reviewed and approved the resident's medication list upon readmission to the facility. Review of the April 2026 Medication Administration Record (MAR) revealed that the resident continued to receive insulin glargine 22 units daily from 4/11 through 4/21/2026 until s/he was transferred back to the hospital on 4/21/2026. During a surveyor interview on 5/11/2026 at 12:46 PM with the Director of Nursing Services (DNS) and the Administrator, they were unable to provide evidence that the cefpodoxime and insulin glargine orders were addressed per the hospital COC after it was reviewed and approved by the provider. Further, they were unable to provide evidence that the pharmacy recommendations that identified the irregularities for the above-mentioned medications were addressed. 2. Record review revealed Resident ID #111 was readmitted to the facility in January of 2026 with a diagnosis including, but not limited to, chronic obstructive pulmonary disorder (COPD) exacerbation. Record review revealed a pharmacy MRR document titled, NURSING RECOMMENDATIONS/NURSE MANAGER REPORT dated 2/11-2/12/2026 states in part, .Repeated rec [recommendation] from January. Please review and correct the following orders that were not transcribed correctly: Anoro ellipta [a daily inhalation powder prescribed for the long term maintenance treatment of COPD that relaxes airway muscles and improve breathing] ordered on [hospital] COC, not entered. Please clarify if this order should be in place. ***Patient on no maintenance inhalers, and has had worsening SOB [shortness of breath]****. Record review failed to reveal evidence that the pharmacy MRR regarding the Anoro ellipta inhaler was addressed when the (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Pawtucket Falls Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 70 Gill Ave Pawtucket, RI 02861	
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	irregularity was initially identified in January 2026 or when the irregularity was readdressed on the above-mentioned pharmacy MRR from February 2026. During a surveyor interview on 5/8/2026 at approximately 11:30 AM with the DNS, she was unable to provide evidence that Resident ID #111's pharmacy MRR recommendation regarding the Anoro ellipta inhaler was addressed by a provider until after it was brought to the facility's attention by the surveyor on 5/11/2026. During a surveyor interview on 5/11/2026 at approximately 10:30 AM with the Physician Assistant, she revealed that she was unaware of the January and February pharmacy MRRs for the Anoro ellipta inhaler and would have ordered it for the resident beginning in January of 2026 if she had been notified. Additionally, she revealed that she will re-instate the resident's Anoro ellipta inhaler that was previously prescribed for the resident prior to his/her readmission to the facility. Record review revealed that the Anoro ellipta inhaler was reinstated on 5/11/2026 after it was brought to the facility's attention by the surveyor. 3. Record review revealed Resident ID #70 was readmitted to the facility on [DATE] with a diagnosis including, but not limited to, ascites (an abnormal buildup of fluid in the abdomen) after a brief hospitalization. Review of a pharmacy MRR document titled, New Admission/re-admission Review dated 5/7/2026 revealed the following significant medication recommendation that required attention:- Furosemide (a medication prescribed to treat excess fluids) is documented on the hospital COC form to administer 20 mg daily, however, the resident is currently receiving 40 mg daily. Additionally, the pharmacy MRR document had a handwritten check mark on the line next to agree with a handwritten note that indicated to change to 20 mg per the hospital COC form. Review of a progress note dated 5/5/2026 at 4:22 PM revealed that a provider reviewed the hospital COC form medication list and discharge paperwork, and that orders were received and initiated as prescribed. Record review failed to reveal evidence that the furosemide order was changed from 40 mg to 20 mg daily. Review of the May 2026 MAR revealed that the resident continued receiving furosemide 40 mg daily from 5/6 through 5/11/2026. Record review revealed a provider's order was entered for the resident to start furosemide 20 mg daily to begin on 5/12/2026, after it was brought the facility's attention by the surveyor on 5/11/2026. During a surveyor interview on 5/11/2026 at 12:46 PM with the DNS and the Administrator, they revealed they would have expected the furosemide medication order to have been transcribed correctly per the hospital COC form after it was reviewed and approved by the provider. Additionally, they would have expected that the pharmacy MRR document regarding the furosemide medication order to have been addressed immediately. 4. Record review revealed Resident ID #73 was admitted to the facility in February of 2025 with diagnoses including, but not limited to, chronic obstructive pulmonary disease and congestive heart failure. Record review revealed the following physician's orders:- 9/10/2025: tiotropium bromide-olodaterol 2.5 - 2.5 micrograms inhale two puffs daily for COPD- 6/28/2025: vascepa administer two grams in the morning and evening for cardiac health. Review of the March 2026 MAR revealed his/her vascepa was not administered, as ordered, on the following dates and times:- 3/16 morning and evening- 3/17 evening- 3/18 morning- 3/19 morning and evening- 3/20 morning and evening- 3/29 morning and evening- 3/30 morning and evening- 3/31/2026 evening. Review of the April 2026 MAR revealed his/her tiotropium bromide was not administered, as ordered, on the following dates:- 4/3- 4/4- 4/5- 4/9- 4/11- 4/12- 4/13- 4/14- 4/15/2026. Record review failed to reveal evidence that the provider was notified that the resident did not receive the above-mentioned medications, as ordered. During a surveyor interview on 5/7/2026 at approximately 11:30 AM with the Nurse Practitioner, she revealed that she was unaware that the resident did not receive the above-mentioned medications and would expect staff to notify her. During a surveyor interview on 5/7/2026 at approximately 12:00 PM with the DNS, she was unable to provide evidence that the resident was kept free from significant medication errors.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on clinical record review and staff interview, the facility failed to ensure the resident's record is accurate, complete, and readily accessible for 1 of 1 resident reviewed with an order for a permacath (a type of central venous catheter that is inserted into a large vein, typically in the chest, to provide long-term vascular access) Resident ID #8. Findings are as follows:Record review revealed the resident was admitted to the facility in October of 2025 with a diagnosis including, but not limited to, end stage renal disease (when the kidneys are no longer functioning to meet the body's needs) and is dialysis dependent (a life-sustaining medical treatment that performs the natural filtering functions of the kidneys when they can no longer function to filter waste and excess fluid from the body).Record review revealed an order dated 5/1/2025 to monitor right chest wall permacath for signs and symptoms of dislodgement or drainage each shift. Record review revealed a progress note dated 9/22/2025 indicating the resident's permacath was removed on this date.Review of the Medication Administration Records for January, February, March, April, and May through 5/7/2026 revealed, staff continued to inaccurately sign off on the order to monitor the right chest wall Permacath, despite documentation that the Permacath had been removed.During a surveyor interview on 5/7/2026 at 12:47 PM, the Director of Nursing Services stated that the resident's Permacath had been removed on 9/22/2025. She further stated she would not expect staff to sign off on an order that was no longer accurate.		

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to notify each resident, or resident representative, that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the Social Security Income (SSI) resource limit for 2 of 2 residents reviewed who required notification, Resident ID #s 21 and 103. Additionally, the facility failed, upon a resident's death, to convey within 30 days the resident's funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate, in accordance with state law for 1 of 1 resident reviewed for personal needs funds handled by the facility that had expired, Resident ID #148. Findings are as follows: 1. 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 . states in part, .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 dated [DATE] revealed the following:-Resident ID #21 has a current balance of \$4,028.86-Resident ID #103 has a current balance of \$3,817.69During a surveyor interview on [DATE] at 10:02 AM, with the Business Office Manager, he revealed that he was unaware that the facility is required to provide written notification to a resident receiving Medicaid benefits or their resident representative when their account balance reached \$200 less than the SSI Medicaid eligibility resource limit (\$4,000).2. According to Rhode Island State Regulation, Section 2.4 (H) of the Uniform Accountability Procedures for Title XIX Resident Personal Needs Funds in Community Nursing Facilities. states in part, .(c) Upon the death of a Medicaid resident, a facility shall, within 10 days, transmit a notarized statement .indicating the amount of personal needs money on hand after funeral expenses. Funeral expenses are designated to be the first paid. Copies of receipts obtained either from the funeral home or the relative responsible for the funeral should be included .(e) If there is a balance in the Medicaid resident's personal needs account, after payment of the above noted disbursements, a check payable to EOHHS in that amount shall be sent along with the copy of the notarized statement and receipts to EOHHS .Record review revealed Resident ID #148 expired in October of 2025 with a remaining balance of \$106.11. Additionally, as of [DATE], his/her personal needs account balance was \$106.11. Record review failed to reveal evidence that resident's funds being held by the facility were conveyed, as required, upon his/her death. During a surveyor interview on [DATE] at 10:02 AM with the Business Office Manager, he acknowledged that the facility still held funds for Resident ID #148.		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure residents were free from misappropriation of property for 2 of 2 residents reviewed during the medication administration task, when medications intended for Residents ID #18 and #115 were administered to Resident ID #90. Findings are as follows: 1. Record review revealed that Resident ID #18 was admitted to the facility in May of 2022 with diagnoses including, but not limited to, essential hypertension and type 2 diabetes mellitus. Additional record review revealed a physician's order dated 8/4/2023 for Metformin HCL (a medication prescribed to treat diabetes) oral tablet 1000 milligrams (MG) by mouth twice a day. 2. Record review revealed that Resident ID #115 was admitted to the facility in May of 2022 with a diagnosis including, but not limited to, hypercholesterolemia (high levels of cholesterol in the blood). Additional record review revealed a physician's order dated 5/14/2025 for Amlodipine Besylate (a medication prescribed to treat high blood pressure) oral tablet 5 MG by mouth daily. 3. Record review revealed Resident ID #90 was admitted to the facility in November 2025 with diagnoses including, but not limited to, essential hypertension and type 2 diabetes mellitus. Additional record review revealed a physician order dated 11/18/2025 for Metformin HCL 1000 mg by mouth twice daily and an order dated 11/19/2025 for Amlodipine Besylate 5 mg by mouth daily. During the medication administration task conducted on 5/7/2026 at 9:03 AM with Certified Medication Technician, Staff O, Resident ID #90 was scheduled to receive Metformin 1000 mg and Amlodipine Besylate 5 mg. When the medications were not available for administration, Staff O obtained Metformin 1000 mg from Resident ID #18 and Amlodipine 5 mg from Resident ID #115 for administration to Resident ID #90 until the surveyor intervened. During a surveyor interview following the above observations, Staff O stated that Resident ID #90 had run out of both medications and acknowledged borrowing the medications from Residents ID #18 and #115. Staff O further stated that borrowing medications from one resident to administer to another was her normal practice. During a surveyor interview on 5/7/2026 at 9:58 AM, with the Director of Nursing Services, she stated that staff should not borrow medications from one resident for administration to another resident. She further stated the above-mentioned medications were available in the emergency medication supply and staff would be expected to obtain the medications from that source.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **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 that each resident receives treatment and care in accordance with professional standards of practice. This included failure to ensure staff completed and documented required weekly skin assessments, reported changes in skin condition to the provider, and initiating timely treatment interventions for 1 of 1 resident observed with a skin impairment, Resident ID #8. Findings are as follows: Review of a facility policy titled, Weekly Body Audit states, in part, .If an alteration in skin integrity, rash, reddened area, or other skin issue is discovered, it will be documented on the weekly skin audit form as soon as the nurse observes the area. the charge nurse is responsible for initiating appropriate documentation, notifying the Unit Manager or Supervisor, and adding this information to the 24-hour report. Record review revealed the resident was admitted to the facility in November of 2024 with diagnoses including, but not limited to, hemiplegia (a form of paralysis affecting one side of the body) and hemiparesis (weakness on one side of the body) affecting the left side. Record review of a Quarterly Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 15 out of 15, indicating the resident's cognition is intact. Additionally, the assessment revealed the resident required substantial to maximum staff assistance with personal hygiene and grooming. Record review of a care plan dated 3/26/2025 revealed the resident is at risk for altered skin integrity related to decreased and impaired mobility. Staff interventions include, but are not limited to, completing weekly skin condition checks. Record review revealed a physician's order dated 1/8/2025 for a weekly skin check to be completed every Wednesday, with findings to be documented in the skin observation assessment. Record review of the May 2026 Medication Administration Record (MAR) revealed that on 5/6/2026, Registered Nurse, Staff P, signed the above-mentioned order as completed. Record review of the weekly skin observation/audit document failed to reveal evidence that Staff P documented findings from the skin assessment completed on 5/6/2026, as ordered and required by the facility policy. Further record review revealed the last documented skin observation/audit was completed on 4/29/2026 and contained no evidence of skin impairment. During a surveyor observation and interview with the resident on 5/6/2026 at 12:05 PM, the resident stated that s/he has had wounds on his/her buttocks for a while that were not being treated by the facility. The resident then lifted his/her left pant leg, revealing two red patches on his/her shin. The resident stated the area was itchy and that s/he was also not receiving treatment for those areas. During a surveyor observation of the resident on 5/7/2026 at 9:12 AM, in the presence of the Unit Manager, Staff N, the resident was observed to have three reddened papules areas (small, solid, raised, inflamed skin bumps) on the left buttock. During an interview immediately following the above observation, Staff N acknowledged the resident's skin impairment and stated she had not previously been aware of it. She further stated she would expect staff to document any skin impairment when identified, notify her of any changes in the resident's skin condition, and notify the provider. During a surveyor interview on 5/7/2026 at 9:51 AM with Rn, Staff P, she acknowledged that she completed the resident's skin check on 5/6/2026 and observed the skin impairment on the resident's left buttock but failed to document the findings. Staff P stated the rash was not newly identified and further acknowledged that she applied lotion to the area but did not notify the Unit Manager or provider. During a surveyor interview on 5/7/2026 at 9:43 AM with the Director of Nursing Services, she was unable to provide evidence that the resident's skin condition had been documented or treated prior to the surveyor bringing it to the facility's attention on 5/7/2026. Record review of a progress note dated (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/8/2026 states, in part, .On exam, several areas of red, flaky, raised rash extending from facial area, navel, to BLE [bilateral lower extremities]. Resident reports feeling very itchy throughout, more prominent to left buttocks.referral to dermatology [skin doctor].agents ordered to relieve symptoms including Clobetasol propionate [a topical medication prescribed to reduce inflammation, redness, itching, and swelling associated with certain skin conditions] 0.05% twice daily for 10 days, and triamcinolone [a medication prescribed to reduce the inflammation, redness, itching, and swelling in various conditions] 0.1% to the navel region and left posterior knee twice daily for 10 days.During a surveyor interview on 5/8/2026 at 11:50 AM with the Physician Assistant, she stated she was unaware the resident had a skin impairment until it was brought to her attention on 5/7/2026, after the surveyor brought it to the attention of the facility.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, and resident and staff interview, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight, for 3 of 3 residents reviewed, who experienced actual weight loss, Resident ID #s 1, 11, and 111. Findings are as follows: Record review of an undated facility policy titled, Nutrition states in part, .it is the policy of this facility to assess all residents/patients and identify those residents/patients at risk for weight loss and provide appropriate interventions according to the physical and mental abilities and his/her wishes. All weight loss/gain of 5 # [pounds] or more if the resident is over 100 #s, or weight loss/gain of 2 # if the resident is less than 100 # requires a re-weight for verification. If significant weight loss/gain is identified (greater than 5% in 30 days or greater than 10% in 6 months), the IDT [interdisciplinary team], Dietician, Physician and Family are notified. All residents with a significant weight loss are reviewed by the interdisciplinary team and the resident/responsible party and interventions implemented as appropriate and are monitored weekly. 1. Record review revealed that Resident ID #1 was admitted to the facility in April of 2026, with diagnoses including, but not limited to, adult failure to thrive and dysphagia (difficulty swallowing). Record review revealed the following physician's orders: -4/10/2026: Diet order for a regular texture diet with thin liquids -4/10/2026: 1 to 1 feeding assistance due to dysphagia and aspiration -4/10/2026: Remeron 15 milligrams (MG) related to anorexia (an eating disorder) Record review of the resident's care plan initiated on 4/13/2026 revealed that the resident is at risk for weight loss related to a diagnosis of diabetes and s/he refuses to eat related to a history of mental illness. Interventions include, but not limited to, monitoring and reporting weight loss. Record review revealed the following weights: -4/10/2026 178.2 pounds (lbs.) -4/30/2026 162.5 lbs. -5/2/2026 162.5 lbs. Record review revealed that the resident experienced a significant weight loss of 8.81% (15.7 lbs.) from 4/10/2026 to 5/2/2026. Further record review failed to reveal evidence that a re-weight was obtained, or that the weight loss was reported to the Registered Dietician (RD) or the provider on 4/30/2026 or 5/2/2026. During a surveyor interview on 5/7/2026 at 2:17 PM with the RD, she revealed that she was not made aware of the weight loss for Resident ID 1. She indicated she was unaware of the facility's process for nursing to report weight discrepancies. She further revealed that it would be her expectation that a re-weight would have been obtained per the facility's policy. 2. Record review revealed that Resident ID #11 was admitted to the facility in September of 2024, with diagnoses including, but not limited to, cerebral infarction (stroke) and dysphagia. Record review revealed the following physician's orders: -4/14/2026: Diet order for a regular texture diet with thin liquids. Chopped meat, weighted utensils, and a scoop plate -4/6/2026: Mirtazapine 7.5 MG for an appetite stimulant Record review of the resident's care plan last revised on 3/9/2026 revealed that the resident has a nutritional problem. Interventions include, but are not limited to, monitoring and reporting weight loss to provider, significant weight loss includes greater than 5% in 1 month, 7.5% in 3 months, 10% in 6 months. Record review revealed the following weights: -2/4/2026 143.2 lbs. -4/6/2026 144.4 lbs. -4/27/2026 129.6 lbs. Record review revealed that the resident experienced a significant weight loss of 9.5% (13.6lbs.) from 2/4/2026 to 4/27/2026. Further record review failed to reveal evidence that a re-weight was obtained, or that the weight loss was reported to the RD or the provider on 4/6/2026 on 4/27/2026. During a surveyor interview on 5/7/2026 at 2:17 PM with the RD, she revealed that she was not made aware of the weight loss for Resident ID 11. She indicated she was unaware of the facility's process for nursing to report weight discrepancies. She further revealed that it would be her expectation that a re-weight (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would have been obtained per the facility's policy. Record review of a progress note dated 5/8/2026 authored by the Physician Assistant, states in part, .Unexplained weight loss Assessment: Patient has unexplained and undesired weight loss with bilateral temporal wasting noted on examination. CT [computed tomogram] scan has been ordered to evaluate underlying cause.3. Record review revealed that Resident ID #111 was admitted to the facility in March of 2021, with diagnoses including, but not limited to, heart failure and dysphagia. Record review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 10 out of 15, indicating the resident has moderately impaired cognition. During a surveyor interview on 5/6/2026 at 11:06 AM, with the resident s/he stated that the food texture provided by the facility revolts and turns his/her stomach. S/he further revealed that s/he believes s/he had some weight loss related to not eating at times. Record review revealed a physician's order dated 1/15/2026 for a minced and moist texture and thin consistency liquids. Record review of the resident's care plan last revised on 3/27/2026 revealed that the resident has a nutritional problem. Interventions include, but are not limited to, monitoring and reporting weight loss to provider, significant weight loss includes greater than 5% in 1 month, 7.5% in 3 months, 10% in 6 months. Record review revealed the following weights: -3/1/2026 210.0 lbs. -3/18/2026 199.2 lbs. -4/1/2026 194.0 lbs. -5/1/2026 190.0 lbs. Record review revealed that the resident experienced a 7.62% (16 lb.) significant weight loss in one month from 3/1/2026 to 4/1/2026. Record review revealed that the resident experienced a 9.52% (20 lbs.) significant weight loss in three months from 3/1/2026 to 5/1/2026. Further record review failed to reveal evidence that a re-weight was obtained, or that the weight loss was reported to the RD or the provider on 3/18, 4/1, or 5/1/2026. During a surveyor interview on 5/7/2026 at 2:17 PM with the RD, she revealed that she was not made aware of the weight loss for Resident ID 111. She indicated she was unaware of the facility's process for nursing to report weight discrepancies. She further revealed that it would be her expectation that a re-weight would have been obtained per the facility's policy. During a surveyor interview on 5/7/2026 at approximately 3:18 PM with the DNS, she revealed that she would have expected a re-weight to be obtained immediately after the weight loss was identified for resident ID's 1, 11, and 111. If the weight loss was verified, the RD and provider should have immediately been notified. Record review of a progress note dated 5/10/2026 authored by the RD states in part, .Resident triggered for significant weight loss. Diet: *Regular diet, *Minced and Moist (Level 5) texture, *Thin consistency Supplement: Health Shake - No Sugar Added 1x daily Resident has had reduced PO [by mouth] intake, which varies. order noted for ST consult. 5/6/2026 Speech Therapy (ST) clarification orders: Recommend S.T. services for 12 visits x 4wks [weeks] to address dysphagia management, diet modification and safe swallow protocol. Reweigh x1 for 5/11/2026.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/11/2026
NAME OF PROVIDER OR SUPPLIER Pawtucket Falls Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 70 Gill Ave Pawtucket, RI 02861	
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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, and staff and resident interview, the facility failed to ensure that residents who requires dialysis (a treatment that removes excess fluid, waste, and toxins from the blood when the kidneys are no longer functioning properly) receive such services consistent with professional standards of practice for 1 of 1 resident reviewed, Resident ID #8. Findings are as follows: Review of a facility policy titled Hemodialysis dated 10/8/2024, states in part, .The facility will coordinate and collaborate with the dialysis facility to assure that the resident's needs related to dialysis treatments are met. Documentation requirements are met to assure that treatments are provided as ordered by the nephrologist [a medical doctor who specializes in diagnosing, treating, and managing diseases and conditions affecting the kidneys], attending practitioner, and dialysis team. The nurse will ensure that the dialysis site .AV fistula [a surgically created connection between an artery and a vein, usually in the forearm or upper arm, designed for long-term hemodialysis access] is checked before and after dialysis treatment every shift for patency by auscultating for a bruit [a swooshing sound that is heard through a stethoscope indicating blood flow in an artery] and palpating for a thrill [a vibration felt on the skin over the access site, indicating blood is flowing properly] .Record review revealed the resident was admitted to the facility in November of 2024 with a diagnosis including, but not limited to, dependence on renal dialysis. Record review of a Quarterly Minimum Data Set assessment dated [DATE] revealed a Brief interview for Mental Status score of 15 out of 15, indicating the resident's cognition is intact. Record review revealed a physician's order dated 2/21/2026 indicating the resident receives outpatient dialysis three times a week on Tuesday, Thursday, and Saturday, and s/he is picked up from the facility at 10:00 AM to go to dialysis. A. Record review revealed a physician's order dated 8/30/2025 for lidocaine external cream 4% (a medication prescribed as a local anesthetic to numb specific areas of the body, providing temporary relief from pain) apply to the dialysis access site daily on Tuesday, Thursday, and Saturday at 4:30 AM before dialysis. Record review of the April 2026 Medication Administration Record (MAR) failed to reveal evidence that the resident had received the lidocaine cream on 4/2, 4/4, 4/7, 4/11, 4/14, 4/18, 4/21, 4/23, 4/25, and 4/30/2026, as ordered. Record review of the May 2026 MAR failed to reveal evidence that the resident had received the lidocaine cream on 5/2, 5/5, and 5/7/2026, as ordered. During a surveyor interview on 5/7/2026 at 12:23 PM with Registered Nurse, Staff C, she acknowledged that she did not administer the resident his/her lidocaine cream on 4/30, 5/2, 5/5, and 5/7/2026 and had signed off the order as being administered. B. Record review of a document titled Hemodialysis Communication Record dated 4/4/2026 states in, .New orders: per [nephrologist]. restart nepro [a high-calorie nutrition supplement prescribed for patients on dialysis] one daily. pt [patient] agreeable. Record review failed to reveal evidence that the above-mentioned recommendation was collaborated with the attending physician at the facility and instituted as per the facility policy. C. Additional record review failed to reveal evidence that the resident's dialysis access site is being assessed by the nurse for a bruit and thrill before and after dialysis treatment, every shift, per the facility's policy. During surveyor interviews on 5/6/2026 at 12:05 PM and on 5/11/2026 at 11:00 AM with the resident, s/he stated that he has an AV fistula on his/her left upper arm that is used for his/her dialysis treatment. The resident further stated that the staff does not apply the lidocaine cream to his/her dialysis site as ordered. Additionally, the resident acknowledged that s/he has not received the nepro for months since it was ordered by the nephrologist. During a surveyor interview on 5/7/2026 at 12:49 PM with the Director of Nursing Services, she was unable to provide (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evidence the lidocaine cream was administered on the above-mentioned dates, as ordered. During a subsequent interview on 5/11/2026 at 12:08 PM, she stated that she would expect the staff to assess the resident's AV fistula for a bruit and thrill each shift and acknowledged that the recommendation for the nepro had not been addressed by the facility. During a surveyor interview on 5/11/2026 at 1:55 PM with the Physician Assistant, she acknowledged that she was not aware of the recommendation from the dialysis center on 4/4/2026 for nepro and would have expected the staff to notify her within, at least, 24 hours of when the recommendation was received. Additionally, she stated that she would have approved the recommendation if she had been made aware.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, and resident and staff interview, the facility failed to have sufficient nursing staff to assure resident safety and attain the highest practicable, physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care for 2 of 2 residents reviewed who failed to receive their scheduled shower due to staffing shortages, Residents ID #s 3 and 122. Findings are as follows: Review of the FACILITY ASSESSMENT dated 2/23/2026 states in part .the residents' daily needs, preferences, and routines in order to help each resident attain or maintain the highest practicable physical, mental, and psychosocial wellbeing. Direct Care Staff .7-8 residents for days (CNA) .Review of an undated policy titled Activities of Daily Living (ADLs) states in part, .that residents unable to carry out ADLs will receive necessary services to maintain grooming and personal hygiene .1. Record review revealed Resident ID #122 was readmitted to the facility in June of 2024 with diagnoses including, but not limited to, morbid obesity (a chronic disease defined by a body mass higher than 40) and urinary incontinence (involuntary loss of bladder control in accidental leakage of urine). Record review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 out of 15, indicating the resident's cognition is intact. It further revealed that the resident is dependent on staff for transfers, requires extensive assistance for bathing/hygiene and dressing, and that the resident is always incontinent of bowel and bladder. Further review of the MDS revealed that the resident's preference to receive shower is very important. Record review of a document titled Assignment for Aides 7-3, Assignment 3 revealed, the resident is scheduled to receive showers twice weekly on Tuesday and Friday. Review of the document titled Task: ADL - Shower/Bathing revealed, the resident is scheduled to receive showers twice weekly on the 7:00 AM to 3:00 PM shift. Review of the shower documentation for the previous 30 days revealed the resident received only one documented shower on 4/23/2026. Further review revealed the resident missed seven scheduled showers during this time period. During a surveyor observation on 5/5/2026 at 11:40 AM, the resident was observed in bed with greasy hair. During an interview conducted at that time, the resident stated showers were not being provided as scheduled and reported that the staff frequently state there are insufficient staff to provide showers. During a surveyor observation and interview with the resident on 5/8/2026 at 11:36 AM, the resident was observed lying in bed and stated that s/he had not yet received morning care. The resident further stated that s/he had experienced a bowel movement approximately one hour earlier and was uncomfortable lying in feces. The resident reported activating the call light at the time of the bowel movement; however, staff did not respond. Additionally, the resident stated that s/he was scheduled to receive a shower that day but was informed by staff that the shower could not be provided due to staffing shortages. During a surveyor interview on 5/8/2026 at 11:40 AM with Licensed Practical Nurse, Staff J, she stated there is no Nursing Assistant (NA) assigned to Resident #122 due to a staffing shortage on the unit. Staff J further indicated that the residents that are scheduled to receive a shower have not been provided one due to insufficient staffing. During a surveyor interview on 5/8/2026 at approximately 12:00 PM with the resident, in the presence of the Director of Nursing Services (DNS), the resident reiterated the above concerns. At that time, the resident had received a bed bath and incontinent care but had not received their preferred scheduled shower. During this interview, NAs, Staff L and Staff M who were in the resident's room stated that they were unable to (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide the resident his/her scheduled shower due to insufficient aides assigned on the unit. 2. Record review revealed that Resident #3 was admitted to the facility in May of 2024 with a diagnosis including but not limited to, type 2 diabetes mellitus. Record review of Quarterly MDS assessment dated [DATE] revealed a BIMS score of 8 out of 15 indicating the resident's cognition is moderately impaired. It further revealed that the resident is dependent on staff for transfers, requires extensive assistance for bathing/hygiene and dressing, and that the resident is always incontinent of bowel and bladder. Further review of the assessment revealed that the resident's preference to receive shower is very important. Record review of the document titled, Assignment for Aides 7-3 Assignment 1 revealed, the resident was scheduled to receive showers twice weekly on Mondays and Fridays. Review of the document titled, Task: ADL - shower/bathing revealed, the resident was scheduled for showers twice weekly on the 7:00 AM-3:00 PM shift. This documentation indicated only one shower was provided on 5/1/2026 within the previous 30 days, indicating that the resident missed seven scheduled showers in 30 days. During a surveyor observation concurrent to the resident interview on 5/8/2026 at 12:11 PM, s/he was observed up, dressed, and sitting in the Geri-chair. S/he stated that s/he had not received his/her scheduled shower for that day. Review of the posted schedule on 5/8/2026 did not reveal evidence that the facility was staffed in accordance with the facility assessment, which indicated a staffing ratio of 7-8 residents per NA. Instead, there were approximately 16 residents assigned to each NA. During a surveyor interview on 5/8/2026 at approximately 1:00 PM with the DNS, she was unable to provide evidence that the unit was adequately staffed and that the residents were receiving care as indicated in the facility assessment. Cross reference F 677		