STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415068	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Operations Ri, LLC Dba Warren Center	642 Metacom Avenue Warren, RI 02885

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and staff interview, it has been determined that the facility failed to implement comprehensive person-centered care plans for 4 of 6 residents reviewed for anticoagulation therapy (a medication that is prescribed to increase the amount of time it takes for blood to clot), Resident ID #s 4, 8, 62, and 64.Findings are as follows:1. Record review revealed Resident ID #4 was readmitted to the facility in May of 2025 with diagnoses including, but not limited to, atrial fibrillation (irregular heart rate) and history of transient ischemic attack (an episode of stroke-like symptoms caused by a brief blockage of blood flow to the brain).Record review revealed a physician's order dated 5/15/2025 for Eliquis 5 milligrams (mg) give one tablet every morning and at bedtime.Record review of a care plan initiated on 5/26/2025 includes a focus area of risk for injury or complications related to Eliquis (a medication prescribed to prevent strokes and blood clots) usage. Additionally, it revealed interventions to observe for signs of active bleeding including bruising, blood in the urine, blood in the stool, nose bleeds or bleeding gums.Record review failed to reveal evidence that the care plan for Resident ID #4 was being implemented relative to observing for signs and symptoms of abnormal bleeding.2. Record review revealed Resident ID #8 was readmitted to the facility in October of 2024 with a diagnosis including, but not limited to, chronic atrial fibrillation.Record review of a care plan initiated on 4/11/2024 includes a focus area of risk for injury or complications related to Eliquis usage. Additionally, it revealed interventions to observe for signs of active bleeding including bruising, blood in the urine, blood in the stool, nose bleeds or bleeding gums.Record review revealed a physician's order dated 10/28/2024 for Eliquis 5 mg give one tablet every morning and at bedtime.Record review failed to reveal evidence that the care plan for Resident ID #8 was being implemented relative to observing for signs and symptoms of abnormal bleeding.During a surveyor interview on 9/19/2025 at 10:30 AM with Registered Nurse (RN), Staff A, she was unable to provide any evidence that Resident ID #s 4 and 8 were being monitored for signs and symptoms of abnormal bleeding.3.Record review revealed Resident ID #62 was admitted to the facility in September of 2025 with diagnosis including, but not limited to, atrial fibrillation.Record review of a care plan initiated on 9/9/2025 included a focus area of risk for injury or complications related to the use of anticoagulation therapy. Additionally, it revealed a goal that resident will not exhibit signs and symptoms of bleeding X 90 days.Record Review revealed the following physician orders:-9/8/2025 for Warfarin Sodium (a medication prescribed to prevent blood clots) give 1.5 mg at bedtime. This order was discontinued on 9/12/2025-9/15/2025 for Warfarin sodium give 1 mg at bedtime. This order was discontinued on 9/16/2025-9/16/2025 for Warfarin sodium give 1 mg at bedtime.Record review failed to reveal evidence that the care plan was being implemented relative to observing for signs and symptoms of abnormal bleeding.4. Record review revealed Resident ID #64 was admitted to the facility in September of 2025 with diagnoses including, but not limited to, atrial fibrillation, embolism (a blockage in the blood vessel caused by a clot) and thrombosis (the formation of a clot) of the superficial veins of the lower extremity.Record review revealed a physician order dated 9/15/2025 for Warfarin Sodium 7.5 mg, give 1 tablet at bedtime.Record review of a care plan initiated on 9/16/2025 included a focus area of risk for injury or complications related to the use of (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	anticoagulation therapy. Additionally, it revealed a goal that resident will not exhibit signs and symptoms of bleeding X 90 days.Record review failed to reveal evidence that the care plan was being implemented relative to observing for signs and symptoms of abnormal bleeding.During a surveyor interview on 9/19/2025 at 10:30 AM with Licensed Practical Nurse, Staff B, she was unable to provide evidence that Resident ID #s 62 and 64 were being monitored for signs and symptoms of abnormal bleeding.

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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. Based on record review and staff interview, it has been determined that the facility failed to ensure that services provided meet professional standards of practice relative to physician's orders, for 1 of 1 resident who receives dialysis (a medical procedure used to remove waste products and excessive fluid from the blood when the kidneys are no longer able to perform this function effectively), Resident ID #7. 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.Record review revealed the resident was admitted to the facility in August of 2025 with diagnoses including, but not limited to, end stage renal disease and dependence on renal dialysis.Record review revealed the following physician's orders:-8/23/2025 cholecalciferol tablet (a dietary supplement) 1,000-unit one tablet daily-8/23/2025 citalopram hydrobromide (an antidepressant) 20 milligrams (mg) one tablet daily-8/23/2025 docusate sodium (a stool softener)100 mg one capsule daily-8/23/2025 ferrous sulfate (an iron supplement) 325 mg one tablet daily-8/23/2025 protein liquid one ounce daily-8/23/2025 quetiapine fumarate (a medication prescribed to treat schizophrenia, bipolar disorder, and major depressive disorder), 25 mg one tablet twice daily-8/22/2025 trazadone (a medication prescribed to treat depression) 50 mg 1/2 tablet from 7:00 AM to 12:00 PMRecord review of the August and September 2025 Medication Administration Records (MARs) failed to reveal evidence that the morning dose of cholecalciferol, citalopram hydrobromide, docusate sodium, ferrous sulfate, protein liquid, and quetiapine fumarate were administered as ordered on the following dates:-8/23/2025-8/26/2025-8/28/2025-9/4/2025-9/6/2025-9/11/2025-9/16/2025Additional review of the September 2025 MAR failed to reveal evidence that the trazadone was administered as ordered on the following dates and times:-9/4/2025, 7:00 AM to 12:00 PM dose-9/11/2025, 7:00 AM to 12:00 PM dose-9/16/2025, 7:00 AM to 12:00 PM doseDuring a surveyor interview on 9/19/2025 at 12:12 PM with the Director of Nursing Services she revealed that she would expect the medications to be administered as ordered. She was unable to provide evidence that the medications were administered on the above dates and times.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on record review and staff interview, it has been determined that the facility failed to provide appropriate treatment and services for 2 of 3 residents reviewed with an indwelling catheter (a flexible tube that collects urine from the bladder and leads to a drainage bag), Resident ID #s 9, and 62.Findings are as follows:According to Brunner & Suddarth's Textbook of Medical-Surgical Nursing Volume 2, 10th Edition, page 1282 states, For patients with indwelling catheters, the nurse assesses the drainage system to ensure that it provides adequate urinary drainage. The color, odor, and volume of urine are also monitored. An accurate record of fluid intake and urine output provides essential information about the adequacy of renal function and urinary drainage.Review of a facility policy titled CATHETER: INDWELLING URINARY-CARE OF states in part, .Monitor urine output color and notify physician.of abnormal changes .1. Record review revealed that Resident ID #9 was readmitted to the facility in June of 2025 with diagnoses including, but not limited to, obstructive uropathy (a blockage in the urinary system that hinders urine flow), urinary retention, acute kidney failure (an abrupt decrease in kidney function) and urinary tract infection.Review of a physician's order dated 8/29/2025 revealed the resident has an indwelling urinary catheter for obstructive uropathy.Record review of a care plan initiated 4/12/2025 revealed the resident requires an indwelling foley catheter relative to obstructive and reflux uropathy with interventions including, but not limited to, monitor output for odor, color, consistency, and amount.Further record review failed to reveal evidence of documentation that urinary output was monitored.2. Record review revealed that Resident ID #62 was readmitted to the facility in September of 2025 with diagnoses including, but not limited to, obstructive uropathy, urinary retention, tubule-interstitial nephritis (inflammation that affects the tubules of the kidneys and the tissues that surround them) and urinary tract infection.Record review revealed the resident has an indwelling urinary catheter for bilateral hydroureteronephrosis (a condition where the ureter and kidney swell due to urine flow obstruction).Record review of a care plan initiated 9/9/2025 reveals the resident requires an indwelling foley catheter relative to obstructive and reflux uropathy with interventions including, but not limited to, monitor output for odor, color, consistency, and amount.Further record review failed to reveal evidence of documentation that urinary output was monitored.During a surveyor interview on 9/19/2025 at 11:22 AM with the Director of Nursing Services, she was unable to provide evidence that the facility provided appropriate treatment and services for residents with a urinary catheter including documenting the urinary output. Additionally, she could not explain how the facility would identify an increase or a decrease in urinary output without the measurement of urine being documented.During a surveyor interview on 9/19/2025 at 1:17 PM with the Medical Director, he indicated it would be his expectation that the resident's output would be documented for resident with an indwelling urinary catheter.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. Based on record review and staff interview it has been determined that the facility failed to have sufficient staff who provide direct services to residents with the appropriate competencies and skill sets to provide nursing and related services, including training on caring for residents with mental and psychosocial disorders as well as residents with a history of trauma and/or post-traumatic stress disorder.Findings are as follows:Record review of the following staff members failed to reveal evidence of trauma informed care in-service training:- Nursing Assistant (NA), Staff D- hired on 5/16/2022- NA, Staff E- hired on 11/2/2024- NA, Staff F- hired on 4/18/2024- NA, Staff G- hired on 4/1/2025During a surveyor interview with the Director of Nursing Services on 9/19/2025 at 8:57 AM, she acknowledged that the trauma informed care in-service was not completed for the above staff members.

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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. Based on record review and staff interview, it has been determined that the facility failed to ensure that residents are free from any significant medication errors for 1 of 1 dialysis resident reviewed, Resident ID #7, and for 1 of 3 residents reviewed relative to blood pressure parameters, Resident ID #38.Findings are as follows: Review of a policy titled, Medication Administration revealed in part, .Prior to administration, review and confirm medication orders for each individual resident.Medications are administered in accordance with written orders of the prescriber.obtain and record any vital sign as necessary prior to medication administration.Medications to be given with meals are to be scheduled for administration at the resident's meal times.If two consecutive doses of a vital medication are withheld or refused, the physician is notified.1. Record review revealed Resident ID #7 was admitted to the facility in August of 2025 with diagnoses including, but not limited to, end stage renal disease and dependence on renal dialysis.Record review of the physician's orders revealed the following:-8/22/2025- Eliquis (a medication prescribed to reduce the risk of strokes and blood clots) 2.5 milligram (mg) one tablet every morning and at bedtime-9/3/2025- Renvela (a medication prescribed to control phosphorus levels in individuals with chronic kidney disease who are on dialysis) 0.8 grams give two packets three times daily at 8:00 AM, 12:00 PM, and 4:00 PM. This order was discontinued on 9/12/2025.- 9/12/2025- Renvela 0.8 gram give two packets three times daily at 8:00 AM, 12:00 PM and 5:00 PM.Record review of the Medication Administration Record (MAR) for September 2025 failed to reveal evidence that the resident received his/her Eliquis as ordered on the following dates and times:-9/4/2025- 7:00 AM- 10:00 AM dose-9/6/2025- 7:00 AM-10:00 AM dose-9/11/2025- 7:00 AM- 10:00 AM dose-9/16/2025- 7:00 AM - 10:00 AM doseRecord review of the Medication Administration Records (MARs) for August and September 2025 failed to reveal evidence that the resident received his/her morning dose of Renvela as ordered on the following dates:-8/26/2025-8/28/2025-8/30/2025-9/4/2025-9/6/2025-9/11/2025-9/13/2025-9/16/2025-9/18/2025During a surveyor interview on 9/19/2025 at 10:11 AM with Registered Nurse, Staff A, she acknowledged that the above medications were not administered as ordered.During a surveyor interview on 9/19/2025 at 10:56 AM with Nurse Practitioner, Staff H, she revealed that she would expect the resident to receive the medications as ordered.During a surveyor interview on 9/19/2025 at 12:12 PM with the Director of Nursing Services (DNS) she revealed that she would expect the medications to be administered as ordered. Additionally, she was unable to provide evidence that the medications were administered on the above dates and times.2. Record review revealed Resident ID #38 was admitted to the facility in May of 2025 with a diagnosis including, but not limited to, hypertension.Record review of the physician's orders revealed the following:-7/17/2025- Metoprolol Tartrate (a medication prescribed to treat high blood pressure) 25 mg one tablet every morning and at bedtime. The order includes the parameters to hold if the systolic blood pressure (is the pressure produced when the heart contracts and pushes out blood) is less than 100 or the pulse is less than 70.Record review of the MARs for August and September 2025 failed to reveal evidence that the resident's morning dose of Metoprolol Tartrate, was held due to parameters as ordered for the 7:00 AM-10:00 AM dose on the following dates:-8/12/2025-pulse of 66-8/16/2025-pulse of 66-8/19/2025-pulse of 67-8/22/2025-pulse of 66-8/29/2025-pulse of 65-8/31/2025-pulse of 67-9/2/2025-pulse of 65-9/5/2025-pulse of 60-9/9/2025-pulse of 63-9/12/2025-pulse of 62-9/16/2025-pulse of 68This indicates that for 11 out of 48 opportunities that the medication was administered outside of the ordered parameters between the dates of 8/1/2025 and 9/17/2025.Record review of the MARs for August and September 2025 failed to reveal evidence that the bedtime doses of Metoprolol Tartrate were held due to the parameters as ordered on the following dates:-8/4/2025-pulse of 69-8/6/2025-pulse of 66-8/8/2025-pulse of 66-8/9/2025-pulse of 69-8/11/2025-pulse of 69-8/15/2025-pulse of 65-8/16/2025-pulse of 67-8/18/2025-pulse of 61-8/20/2025-pulse of 64-8/21/2025-pulse of 60-8/22/2025-pulse of 60-8/23/2025-pulse of 67-8/24/2025-pulse of (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	65-8/27/2025-pulse of 69-8/28/2025-pulse of 62-8/29/2025-pulse of 62-8/30/2025-pulse of 68-9/6/2025-pulse of 69-9/8/2025-pulse of 60-9/9/2025-pulse of 53-9/10/2025-pulse of 64-9/14/2025-pulse of 66-9/15/2025-pulse of 62This indicates that for 23 out of 47 opportunities that the medication was administered outside of the ordered parameters between the dates of 8/1/2025 and 9/16/2025.During a surveyor interview on 9/18/2025 at 12:30 PM with Certified Medication Technician, Staff I, she acknowledged that the Metoprolol Tartrate was signed off as administered when the resident's pulse was less than 70.During a surveyor interview on 9/18/2025 at 12:35 PM with Licensed Practical Nurse, Staff J, she acknowledged that the Metoprolol Tartrate was given outside of parameters on the above dates.During a surveyor interview on 9/18/2025 at 12:40 PM with the DNS she acknowledged that the Metoprolol Tartrate should have been held due to a pulse below 70 on the above dates and times.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide residents with the right to personal privacy and confidentiality of his/her personal and medical records relative to the posting of past survey results.Findings are as follows:During a surveyor observation of the main lobby area on 9/19/2025 at 7:30 AM, revealed a survey results binder.Record review of the survey results binder revealed copies of a previous recertification survey dated 8/16/2024 including the resident/staff roster which contained identifying information for 12 residents.During a surveyor interview on 9/19/2025 at 12:12 PM with the Administrator, she was unable to provide evidence that the facility protected the identifying information of the 12 residents listed in the survey results binder.

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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, record review, and staff interview, it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice relative to monitoring of intake and output for 1 of 1 resident reviewed, Resident ID #59.Findings are as follows:According to Nursing, A Concept-Based Approach to Learning, Third Edition, Volume 1 dated 2019, page 366 and 370, acute kidney injury (AKI) is a rapid loss of renal function often accompanied by oliguria (voiding less than 500 milliliter [mL] per day) and electrolyte imbalance. A primary nursing intervention for AKI is closely monitoring the patient's fluid balance by tracking all intake and output over a 24-hour period, including oral fluids, ice chips, liquid foods, parenteral fluids, urine, emesis (vomit), liquid stool, and wound drainage.Record review revealed that the resident was admitted to the facility in June of 2025 with diagnoses including, but not limited to, cerebral infarction (stroke) and acute kidney injury with a creatinine level of 4.98 milligrams per deciliter (mg/dL) (a laboratory test that measures a person's kidney function with a normal range of 0.6 - 1.3 mg/dL. An elevated creatinine may be the result of kidney failure, dehydration, and other health condition).Record review revealed the resident was re-hospitalized on [DATE] with a continued diagnosis of AKI with a creatinine level of 5.93 mg/dL. S/he was sent back to the facility with the following recommendations including, but not limited to, have him/her drink at least 64 ounces (1892 milliliters) of liquids by 3:00 PM each day and if s/he has not consumed that amount of liquid by 3:00 PM, to administer 1 liter of normal saline. Additionally, if s/he stops making urine, stops eating or drinking, have him/her return to the emergency department for reevaluation.Record review of a physician progress notes written by Physician, Staff C, dated 6/17/2025 at 12:00 AM, revealed the resident was hospitalized on [DATE] due to an elevated creatinine of approximately 6 mg/dL and returned to the facility. The physician documented that the resident should be on strict intake and output to monitor his/her kidney function.Record review failed to reveal evidence that strict intake and output monitoring was implemented. During a surveyor interview on 9/19/2025 at 10:28 AM with the Physician, Staff C, she acknowledged that her expectation would be for the nurses to follow through with the strict intake and output monitoring as documented in her note.During a surveyor interview on 9/19/2025 at 10:55 AM with the Director of Nursing Services in the presence of the Administrator, she was unable to provide evidence that a strict intake and output monitoring was implemented for the resident.