Printed: 04/02/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415072	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmwood Nursing and Rehabilitation Center	225 Elmwood Avenue Providence, RI 02907

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to inform the resident's appointed representative, in advance, of the care to be furnished by the physician or other provider, of the risks and benefits of proposed care or treatment alternatives relative to the ordering and administration of an antipsychotic medication for 1 of 1 resident reviewed, for the use of Zyprexa (an atypical antipsychotic medication), Resident ID #2.Findings are as follows:Review of the facility policy titled, Medication Administration Safety, Psychotropic Medications and New Medication Orders dated 4/28/2025 states in part, .Any and all psychotropic medications require resident or representative consent. Consent must include their awareness of the medication(s) ordered, the side effects to include black box warnings when applicable, and the risk/benefit.consent is necessary prior to administration of these medications medications.If/When a new medication is ordered, this signals a change in resident condition and the.Representative must be notified of that change.The progress notes (or other form being used in the medical record) must show evidence of this notification .Record review revealed the resident was readmitted to the facility in October of 2025 with a diagnosis including, but not limited to, encephalopathy (a term used to describe any disorder or disease that affects the brain leading to dysfunction. Brain dysfunction can appear as confusion, memory loss and personality changes).Review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score was not conducted as the resident is rarely/never understood.Review of a progress note dated 10/27/2025, authored by the Physician, revealed that the resident has been pulling out his/her catheter (a thin flexible tube that is inserted through the urethra to help drain urine from the bladder), wound vac (is a medical treatment that uses a vacuum device to apply controlled suction to wounds. This therapy helps to promote healing by reducing swelling, increasing blood flow, and creating a moist environment conducive to tissue regeneration) and refusing care. Additional review revealed an order for Zyprexa 5 milligrams (mg) for agitation.Further record review failed to reveal evidence that resident's representative was informed regarding the order for Zyprexa or of the risks, benefits, and alternatives to the medication.Review of the October, November and December 2025 Medication Administration Records (MAR) revealed that the resident received Zyprexa 5 mg daily from 10/27/2025 through 12/31/2025. Further review of the January 2026 MAR revealed that the resident received Zyprexa 5 mg daily from 1/1/2026 to 1/13/2026. During a surveyor interview on 1/14/2026 at approximately 2:00 PM with the Director of Nursing Services, she was unable to provide evidence that the order for Zyprexa was reviewed with the resident's representative prior to the initiation of the medication on 10/28/2025.

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

Printed: 04/02/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415072	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmwood Nursing and Rehabilitation Center	225 Elmwood Avenue Providence, RI 02907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on clinical record review and staff interview, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice relative to following physician's orders for a neurology consult and psychiatric services for 1 of 1 resident reviewed, Resident ID #2.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 the orders are in error or would harm the clients.Record review revealed the resident was readmitted to the facility in October of 2025 with diagnoses including, but not limited to, encephalopathy (a term used to describe any disorder or disease that affects the brain leading to dysfunction. Brain dysfunction can appear as confusion, memory loss and personality changes) and cardiac arrest (heart attack).1a. Record review revealed a physician's order dated 10/6/2025, for a neurology consult related to recent shock (an acute medical condition associated with a fall in blood pressure.)Additional record review failed to reveal evidence that the neurology consult appointment was scheduled or completed after it was ordered 10/6/2025.1b. Record review revealed of a physician's order dated 10/16/2025, to obtain a psychiatric and psychological health evaluation.Record review of a psychiatric evaluation and consultation form dated 10/28/2025, revealed the current assessment plan included a follow up in 30-45 days.Further record review failed to reveal evidence that the resident was seen for a psychiatric follow up after the above-mentioned assessment.During a surveyor interview on 1/13/2026 at 4:04 PM with the Physician, he indicated he would have expected that the facility to schedule the neurology consultation for the resident. Additionally, he indicated it would be his expectation for the resident to have been seen for psychiatric follow up.During a surveyor interview on 1/13/2026 at 4:16 PM, with the Director of Nursing Services, she was unable to provide evidence that the resident was seen by psychiatric services for follow up. Additionally, she was unable to provide evidence that the neurology consultation was scheduled or completed for the resident.