| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 415078 | A. Building<br>B. Wing | 04/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Coventry Operations RI LLC Dba Respiratory and Reh | 10 Woodland Drive<br>Coventry, RI 02816 |

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| F 0805<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>Based on surveyor observation, clinical record review, and staff interviews, the facility failed to ensure a system was in place to prepare and serve fluids in a form designed to meet residents prescribed dietary needs. Specifically, the facility failed to ensure nectar thick liquids (mildly thick fluid consistency required to promote safe swallowing) were prepared according to physician's orders for 1 of 1 resident reviewed who was prescribed nectar thick liquids, Resident ID #21. Additionally, the current styrofoam cup supply, located on 4 of 4 units, was found to consist of 16 fluid (fl.) ounce (oz.) cups instead of the 12 fl. oz cups that were posted in the facility for staff to use for guidance and instructions when preparing thickened liquids. This failure reflects a breakdown in the facility's system for implementing and monitoring prescribed diet modifications and placed residents at risk for choking, aspiration, and other serious complications related to swallowing impairments. Findings are as follows:Record review revealed that Resident ID #21 was admitted to the facility in May of 2025 with diagnoses including, but not limited to, chronic obstructive pulmonary disease and dysphagia (difficulty swallowing).A. Record review revealed a physician's order dated 10/9/2025, for a mechanical soft diet texture and nectar thick liquids.Record review of a Speech Therapy document titled, Evaluation and Plan of Treatment dated 3/11/2026 revealed a fiberoptic endoscopic evaluation of swallowing (FEES, a diagnostic procedure used to assess swallowing function, particularly in individuals with dysphagia) in October of 2025 which revealed aspiration of thin liquids. Further review revealed that Resident ID #21 continues to work with a Speech Therapist four times a week.During a surveyor observation on 4/6/2026 at approximately 12:05 PM, the resident was observed with a large white styrofoam cup containing a red liquid that appeared to be of a thin consistency.During a surveyor interview at the time of the above observation with Resident ID #21, s/he revealed that s/he had already consumed some of the red liquid and stated, I knew it was too thin.During a survey observation and interview immediately following the above observation with the Unit Manager, Licensed Practical Nurse, Staff A, she acknowledged that the consistency of the liquid provided to Resident ID #21 was thin and not of a thickened consistency.During a surveyor interview on 4/6/2026 at 12:12 PM with Nursing Assistant (NA), Staff B, she revealed that she was unaware that the resident required nectar thick liquids. She presented her assignment sheet to the surveyor which indicated the resident required nectar. When asked by the surveyor how she would prepare nectar thick liquids, she was unable to answer. When asked how many fl. oz. were in the cup provided to the resident, she indicated that she gave the resident a 12 oz cup which was not thickened.B. Review of a facility document located in the kitchenettes, on 4 of 4 units, revealed a laminated staff guide with instructions for preparing thickened liquids. This document depicted photos of 5 different size cups indicating the fl. oz. for each cup and how to prepare thickened beverages. The Large Styrofoam cup picture states, 12 oz .3 Nectar Packets .Review of a packet of the thickening agent provided by the facility titled, THICK & EASY states in part, Directions: Add 1 packet.to 4fl. oz of liquid. Stir with a spoon or fork for approximately 15 seconds or until thickener is dissolved. Allow 1-4 minutes for product to reach desired thickness.During a surveyor interview on 4/6/2026 at 12:10 PM with the Speech Therapist, she revealed that the large styrofoam cup given to the resident was 12 fl.<br>(continued on next page) |

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

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

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| F 0805<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | oz. and requires 3 packets of the thickening agent to achieve a nectar thickened consistency. Additionally at this time she prepared the resident an alternative drink and stated, I added three packets into this 12 fl. oz. cup.During a surveyor interview on 4/6/2026 at 12:18 PM with NA, Staff C, he revealed that the large Styrofoam cups were 12 fl. oz and required 3 packets of the thickening agent to achieve a nectar thickened consistency.Further review of the large styrofoam cups provided to the residents on 4 of 4 units, revealed that they were 16 fl. oz and not 12 fl. oz, which would require 4 packets to achieve the prescribed nectar consistency.During a survey interview on 4/6/2026 at 1:25 PM with the Central Supply Coordinator, Staff D, he revealed that the large styrofoam cups on the units are 16 fl. oz. He further provided the box that the Styrofoam cups come in, which indicated they are 16 fl. oz.During a surveyor interview on 4/6/2026 at 2:17 PM with the Director of Nursing Services, she revealed that she would expect staff to prepare drinks according to the prescribed orders for the liquid consistency and according to the manufacturer's instructions. She further acknowledged that the cups on the units were 16 fl. oz cups not the 12 fl. oz cups on the sheets provided to staff.The facility's failure to implement and maintain a safe system for the preparation of prescribed thickened liquids, including the use of the correct fluid ounce measurements per manufacturer's instructions, resulted in staff preparing thickened liquids inaccurately, leading to incorrect consistencies. This systemic failure placed residents with dysphagia at risk for aspiration, choking, aspiration pneumonia, and other serious complications that could result in serious injury, harm, impairment, or death. |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observe each nurse aide's job performance and give regular training.<br><br>Based on record review and staff interview, the facility failed to complete an annual performance review for every nurse aide (NA) at least once every 12 months, for 5 of 5 NAs' personnel records reviewed, Staff I, J, K, L and M.Findings are as follows:Record review of the following personnel files failed to reveal evidence that an annual performance evaluation was completed for the following NAs:-Staff I, with a hire date of 3/15/2000-Staff J, with a hire date of 11/11/2013-Staff K, with a hire date of 1/21/2025-Staff L, with a hire date of 3/29/2001-Staff M, with a hire date of 7/11/2024During a surveyor interview on 4/10/2026 at 11:15 AM with the Director of Nursing Services, she was unable to provide evidence of performance evaluations for the above-mentioned employees that were completed within the last 12 months. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on clinical record review and staff interviews, the facility failed to ensure that irregularities identified by the Consultant Pharmacist during the monthly Medication Regimen Review (MRR) were acted upon for 4 of 4 residents reviewed with outstanding pharmacy recommendations from prior months, Resident ID #s 6, 29, 84, and 107. Findings are as follows:According to the facility policy dated 1/2024 and titled, Medication Monitoring Medication Regimen Review and Reporting, which states in part, .8. The nursing care center follows up on the recommendations to verify that appropriate action has been taken. Recommendations should be acted upon within 30 calendar days.1. Record review revealed Resident ID #6 was admitted to the facility in February of 2024 with diagnoses including, but not limited to, chronic diastolic heart failure (a condition when the left ventricle, thickens, stiffens and does not fully relax between beats), schizophrenia (a chronic severe brain disorder causing psychosis), neuropathy (damage to the nerves causing weakness, numbness, and pain usually in the hands and feet) and coronary artery disease (a condition where the major blood vessels supplying the heart become damaged due to a build-up of plaque).Record review revealed a document titled, Consultant Pharmacist's [MRR] Recommendations Pending a Final Response, with review dates between 3/22/2026 and 3/26/2026 indicating that the resident's previous pharmacy review, dated 2/17/2026, made the following recommendations for his/her high-risk medication monitoring:- Diuretic: Furosemide, monitor for signs and symptoms of dehydration, electrolytes, acute kidney injury, monitor for edema, congestion, weight changes- Anticonvulsant: Gabapentin, monitor for signs of seizures, pain assessment, changes in behaviors, therapeutic drug levels, rash, fever and dizziness- Antipsychotic: Paliperidone and Rexulti, monitor side effects including dry mouth, constipation, blurred vision, change in urination, jerking movements in the face, tongue and jaw, swelling in hands, ankles or feet, drooling, disturbed gait and restlessness.- Antiplatelet: Aspirin, monitor for signs/symptoms of bleeding/bruising and monitor for signs/symptoms of thromboembolism Record review failed to reveal evidence that the above monitoring recommendations were implemented.Additionally, it was not until 4/9/2026, after the surveyor had asked the facility to review the resident's MRR document, that the provider signed in agreement with the above-mentioned recommendations, from February and March 2026. During a surveyor interview on 4/10/2026 at approximately 2:30 PM with the Director of Nursing Services, she was unable to provide evidence that Resident ID #6's MRR recommendations, initially made in February of 2026, were acted upon by the provider within 30 days as per the facility's policy.2. Record review revealed that Resident ID #29 was admitted to the facility in November of 2022 with diagnoses including, but not limited to, cerebral infarction (stroke) and hyperlipidemia (high cholesterol).Record review revealed a physician's order dated 2/8/2025 for Atorvastatin Calcium (a medication prescribed to treat high cholesterol) 20 milligrams (mg) daily.Record review of an MRR document dated 1/20/2026, revealed a recommendation from the pharmacist to obtain laboratory tests for a baseline and annual liver function test (LFTs) and a lipid panel (a blood test that measures the level of cholesterol and triglycerides in the blood) to monitor therapeutic effects and side effects of atorvastatin.Record review of an MRR document dated 3/25/2026, revealed a repeat recommendation from the pharmacist to obtain laboratory tests for a baseline and annual liver function test (LFTs) and a lipid panel to monitor therapeutic effects and side effects of atorvastatin.Record review of a nursing progress note dated 4/9/2026 at 12:14 PM states in part, Pharmacy rec received and reviewed by [provider]. N.O [new order] for LFT and lipid panel on Monday, then yearly after that.Record review revealed a physician's order dated 4/9/2026 for laboratory tests for LFTs and a lipid panel once on 4/13/2026 and yearly.During a surveyor interview on 4/10/2026 at 10:42 AM with the Physician Assistant, Staff G, he revealed that he was made aware of the above pharmacy recommendations for Resident ID #29 on 4/9/2026 and agreed with the recommendations from 1/20/2026 and 3/25/2026. 3. Record review<br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | revealed Resident ID #84 was admitted to the facility in September of 2025 with diagnoses including, but not limited to, major depressive disorder and anxiety.Record review revealed a physician's order dated 2/7/2026 for Trazodone 50 mg daily as needed (prn) for anxiety and agitation.Record review of an MRR document dated 2/19/2026, revealed a recommendation from the pharmacist which states in part, .please evaluate current diagnosis, behaviors and usage pattern.psychotropic [a class of medications that affects behaviors, mood, thoughts, or perceptions] order cannot exceed 14 days.Record review failed to reveal evidence that the above-mentioned MRR was reviewed and acted upon by the provider.During a surveyor interview on 4/10/2026 at 2:16 PM with Nurse Practitioner, Staff N, she revealed that she was not made aware of the MRR dated 2/19/2026 until 4/9/2026, after it was brought to the facility's attention by the surveyor. Additionally, she acknowledged that she approved the pharmacy recommendations.4. Record review revealed Resident ID #107 was admitted to the facility in February of 2025 with diagnoses including, but not limited to, cerebrovascular disease (a group of conditions that affect blood vessels and blood circulation to the brain), hypotension (low blood pressure), and Vitamin D deficiency (low Vitamin D levels).Record review of an MRR document date 2/18/2026 revealed a recommendation from the pharmacist, indicating that the resident is receiving medications that require routine lab work to include, basic metabolic panel (a blood test that checks the body's fluid balance, levels of electrolytes, and kidney function), complete blood count (a group of blood tests that measures the number and size of the different cells in the blood), and Vitamin D (a blood test that measures the level of Vitamin D in the body).Record review failed to reveal evidence that the above-mentioned MRR was reviewed and acted upon by the provider within 30 days as per the facility's policy, until it was brought to the facility's attention by the surveyor on 4/9/2026.During a surveyor interview on 4/10/2026 at 11:07 AM with Physician Assistant, Staff G, he revealed that he was not made aware of the MRR recommendations from 2/18/2026, until 4/9/2026, and that is when he approved the recommendation. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>Based on clinical record review and staff interviews, the facility failed to ensure a resident's drug regimen is free from unnecessary drugs for 1 of 1 resident reviewed receiving Midodrine (a medication prescribed to treat low blood pressure), Resident ID #13.Findings are as follows:Record review of a facility policy titled, Medication Administration last revised in January of 2023, states in part, .General Guidelines.Medications are administered in accordance with written orders of the prescriber.Record review revealed the resident was re-admitted to the facility in February of 2022 with a diagnosis including, but not limited to, hypotension (low blood pressure).Record review revealed a physician's order dated 2/17/2026 for Midodrine 2.5 milligrams (mg) three times a day for hypotension, with parameters to hold the medication if the systolic blood pressure (SBP; refers to the top number of a blood pressure reading and indicates the pressure in your arteries when your heart contracts) is greater than 110.Record review of the March and April 2026 Medication Administration Records revealed the Midodrine was administered when the resident's SBP was outside of the ordered parameters on the following dates and times:3/1/2026 evening dose, SBP of 1263/2/2026 evening dose, SBP of 1123/3/2026 afternoon dose, SBP of 1263/4/2026 morning dose, SBP of 1123/7/2026 afternoon dose, SBP of 1203/8/2026 afternoon dose, SBP of 112; evening dose, SBP of 1183/13/2026 evening dose, SBP of 1203/14/2026 evening dose, SBP of 1203/15/2026 evening dose, SBP of 1183/20/2026 morning dose, SBP of 1193/24/2026 morning dose, SBP of 1143/25/2026 morning dose, SBP of 1183/28/2026 morning dose, SBP of 1164/6/2026 evening dose, SBP of 118During a surveyor interview on 4/9/2026 at 4:28 PM with Licensed Practical Nurse, Staff O, she acknowledged that the resident was administered Midodrine when his/her SBP was greater than 110 on the above dates and times, indicating the resident received the medication when s/he should not have.During a surveyor interview on 4/10/2026 at 12:52 PM with the Physician Assistant, Staff G, he indicated that he would expect that the Midodrine would be held if the resident's SBP is greater than 110.During a surveyor interview with the Director of Nursing Services on 4/10/2026 at 1:24 PM, she indicated that she would expect the Midodrine to be held on the above-mentioned dates and times, per the physician's order. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, and staff interviews, the facility failed to store and label drugs and biologicals in accordance with currently accepted professional principles for 1 of 2 medication storage rooms observed and 3 of 4 medication carts observed. Findings are as follows:Record review of the facility policy dated [DATE], titled Medication Storage states in part, Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to keep their integrity.the provider pharmacy dispenses medications in containers that meet state and federal labeling requirements.Medications requiring 'refrigeration' .are kept in the refrigerator.Note the date on the label for insulin vials and pens when first opened. Outdated.discontinued medications .are immediately removed from stock.During a surveyor observation on [DATE] at 11:59 AM of the Third-Floor medication storage room, in the presence of Registered Nurse (RN), Staff P, revealed two packets of acetaminophen (pain and fever reducer) suppositories 650 milligram (mg) with expiration dates of 3/2026.During a surveyor interview with Staff P, immediately following the above-mentioned observation, she acknowledged the suppositories were expired.2. During a surveyor observation on [DATE] at 12:09 PM of the One North Low-Side medication cart, in the presence of RN, Staff Q revealed the following:-Humalog 100 unit/milliliter (ml) insulin (a medication prescribed to treat diabetes) vial with an open date of [DATE]. Manufacturer instructions indicate to discard the insulin 28 days after opening.-Solu-Medrol 125 mg vial (a medication prescribed to treat inflammation) without a pharmacy label that indicated a resident identifier.-Lorazepam Intensol (a medication prescribed to treat anxiety) 2 mg/ml with a manufacturer's label indicating to store this medication in the refrigerator.During a surveyor interview with Staff Q immediately following the above-mentioned observations, she acknowledged that the insulin had expired and the Solu-Medrol did not have a resident identifier. Additionally, she acknowledged that the Lorazepam should have been stored in the refrigerator and not in the medication cart.3. During a surveyor observation on [DATE] at 12:33 PM of the one north high-side medication cart, in the presence of Licensed Practical Nurse (LPN), Staff R revealed a bottle of Lorazepam Intensol 2mg/ml with a manufacturer's label indicating to store this medication in the refrigerator.During a surveyor interview with Staff R immediately following the above-mentioned observation, she acknowledged the Lorazepam should have been stored in the refrigerator was revealed.4. During a surveyor observation on [DATE] at 12:42 PM of the One South medication cart in the presence of RN, Staff S, and Unit Manager, LPN, Staff T, revealed the following:-Insulin Lispro 100 unit/ml vial with an opened date of [DATE]. Manufacturer's instructions indicate to discard the insulin 28 days after opening-Lorazepam Intensol 2 mg/ml with a manufacturer's label indicating to store the medication in the refrigerator-Lantus 100 unit/ml insulin pen, opened and not dated. Manufacturer's instructions indicate to discard the insulin 28 days after opening-Morphine Sulfate (a medication prescribed to treat pain) 100 mg/5ml with a discontinued date (d/c) of [DATE]-Tramadol 25 mg (a medication prescribed to treat pain) tablets with a d/c date of [DATE]-Hydrocodone/acetaminophen 10-325 mg (a medication prescribed to treat pain) with a d/c date of [DATE]-Alprazolam 1 mg (a medication prescribed to treat anxiety) with a d/c date of [DATE]-Oxycodone 5mg (a medication prescribed to treat pain) with a d/c date of [DATE]During a surveyor interview with Staff S, she acknowledged that the insulin Lispro should have been discarded, and the Lantus insulin should have been dated when opened. She further acknowledged that the Lorazepam should have been refrigerated. During a subsequent interview with the Staff T, he acknowledged the above-mentioned medications that were discontinued should have been removed from the medication cart and discarded.During a surveyor interview on [DATE] at 1:19 PM with the (continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Director of Nursing Services, she revealed that the discontinued medications should have been removed from the medication cart and destroyed. She further indicated that insulins should be dated when opened and medications that need to be refrigerated should be stored in the refrigerator. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, record review, and staff interviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, relative to 3 of 4 kitchenettes.Findings are as follows:1. Review of the 2022 Food Code published by the U.S. Food and Drug Administration (FDA), Section 4-601.11 (C), states in part, .non-contact surfaces of equipment shall be free of an accumulation of .other debris .During a surveyor observation on 4/9/2026 at 11:15 AM, of the One North Unit kitchenette, the microwave was noted to have an accumulation of red/orange dried matter on the ceiling, inside the microwave.During a surveyor interview immediately following the above observation with Dietary Aide, Staff U, she acknowledged that the microwave was dirty and needed to be cleaned.During a surveyor observation on 4/9/2026 at 11:26 AM, of the One South Unit kitchenette, the microwave was noted to have dried splatters and stains of various colors, located on the ceiling and walls inside the microwave.During a surveyor interview, immediately following the above observation with Licensed Practical Nurse, Staff V, she acknowledged the dried splatters inside the microwave and indicated that the microwave needed to be cleaned.2. Review of the 2022 Food Code published by the U.S FDA Section 3-501.17 (A) states in part, .READY -TO-EAT-TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the premises, sold, or discarded when held at a temperature of 5 degrees Celsius or 41 degrees Fahrenheit or below for a maximum of 7 days. The day of preparation shall be counted as Day 1 .Review of an undated facility policy titled, Food Brought in from Outside Sources and Personal Food Storage, states in part, .Foods and beverages brought in from outside sources that require refrigeration or freezing will be labeled with the patient/resident's name and date and stored in the refrigerator/freezer apart from facility food.During a surveyor observation on 4/9/2026 at 11:15 AM, of the One North Unit kitchenette, the following was observed in the refrigerator:-Ten 2-ounce (oz.) cups of pudding and applesauce, eight of which had a use-by date of 4/8, one with a use-by date of 4/1, and one with a use-by date of 4/5-One paper bag containing take-out food, labeled with a resident's name and the date of 4/5During a surveyor interview immediately following the above observations with Staff U, she acknowledged that the pudding and applesauce cups were beyond their use-by dates and needed to be thrown away. She also acknowledged that the bag of take out food had been in the refrigerator beyond three days and needed to be discarded.During a surveyor observation on 4/9/2026 at 11:26 AM, of the One South Unit kitchenette, the following was observed in the refrigerator:-One peanut butter and jelly sandwich with a use-by date of 4/8-One chef's salad with a use-by date of 4/8-Two 2 oz. cups of applesauce, one 2 oz. cup of vanilla pudding, and one 2 oz. cup of chocolate pudding with use-by dates of 4/8During a surveyor interview immediately following the above observation with Licensed Practical Nurse, Staff V, she acknowledged the above food items were beyond their use-by dates and needed to be discarded.During a surveyor observation on 4/9/2026 at 11:40 AM of the Two South Unit kitchenette, the following was observed in the refrigerator:-One peanut butter and jelly sandwich with a use-by date of 4/8-One 96 oz. container of Lactaid whole milk, 2/3 consumed, with an open date of 3/16. Manufacturer's instructions indicate that once opened, it should be consumed within 14 days.-One 96 oz. container of Lactaid whole milk, 2/3 consumed, with an open date of 3/3. The resident's name was illegible in yellow marker and had partially rubbed off.-One 12 oz. container of hickory smoked ham salad, opened and undated. Manufacturer's instructions state to use within 5 to 7 days after opening.-One 22 oz. container of [NAME] Shack rice pudding, opened 3/11, with a use-by date of 5/26. The container of rice pudding was noted to have a sour smell. Manufacturer's instructions state once opened, consume within a few days. If the pudding looks, smells, or tastes off, it should always<br>(continued on next page) |

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|---|---|---|---|
| | 415078 | A. Building<br>B. Wing | 04/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Coventry Operations RI LLC Dba Respiratory and Reh | 10 Woodland Drive<br>Coventry, RI 02816 |

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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | be discarded.During a surveyor interview on 4/9/2026 at 11:52 AM, Staff U, she acknowledged the above concerns in the Two South kitchenette refrigerator.During a surveyor interview on 4/9/2026 at 12:09 PM with the Assistant Kitchen Manager, Staff W, he acknowledged all of the above concerns and indicated that food items should be dated when opened and thrown out when they are expired. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Based on clinical record review and staff interviews, the facility failed to ensure that resident records are complete and accurately documented for 1 of 1 resident reviewed for 15-minute checks, Resident ID #9; for 1 of 1 resident reviewed for hand splints, Resident ID #52; and for 1 of 1 resident reviewed with a physician's order to flush his/her Gastrostomy tube (G-tube, a medical device inserted through the abdomen directly into the stomach to provide long-term nutritional support, fluids, and medication) before and after each feeding, Resident ID #71.Findings are as follows:1. Record review revealed Resident ID #9 was readmitted to the facility in January of 2026 with a diagnosis including, but not limited to, dementia with psychotic disturbance.Record review revealed a progress note dated 4/4/2026 which revealed the resident was involved in a physical altercation with another resident, where Resident ID #9 hit him/her on the arm. Further review revealed Resident ID #9 was going to be placed on 15-minute checks over the weekend.Record review revealed a physician's order dated 4/4/2026 for 15-minute checks every shift, until 4/12/2026.Review of a document titled, 15-30-60 Minute Patient Observation Checks, dated 4/4/2026 to 4/5/2026 revealed incomplete documentation on 4/5/2026 from 8:45 AM until 2:45 PM.Review of a document titled, 15-30-60 Minute Patient Observation Checks, dated 4/5/2026 to 4/6/2026 revealed incomplete documentation on 4/6/2026 from 7:15 AM until 10:45 PM.Review of a document titled, 15-30-60 Minute Patient Observation Checks, dated 4/7/2026 to 4/8/2026 revealed incomplete documentation on 4/8/2026 from 7:15 AM until 11:15 AM; this concern was brought to the facility's attention by the surveyor at this time. During a surveyor interview on 4/8/2026 at 11:15 AM, with Licensed Practical Nurse (LPN), Unit Manager, Staff O, she revealed the resident was on 15-minute checks as an intervention, following a physical altercation involving another resident on 4/4/2026. She revealed that the Nursing Assistants complete the documentation on the forms but indicated it is the nurse's responsibility to ensure they are completed. She acknowledged the incomplete documentation on the above-mentioned dates and indicated that she had worked during the day on 4/5/2026 and acknowledged she did not ensure the 15-minute checks were completed as ordered, and documented during her shift, as ordered.During a surveyor interview on 4/8/2026 at 1:14 PM, with the Director of Nursing Services (DNS), she revealed that she would expect the 15-minute checks to be completed in their entirety, as ordered.2. Record review revealed Resident ID #52 was admitted to the facility in March of 2021 with diagnoses including, but not limited to, anoxic brain damage (occurs when the brain is deprived of oxygen) and persistent vegetative state.Review of a care plan focus area initiated on 3/31/2021 revealed Resident ID #52 is dependent upon staff for activities of daily living. An intervention includes, but is not limited to, bilateral splints placed in the morning and removed at night, as tolerated.Record review revealed a physician's order dated 10/12/2022 to apply bilateral hand splints after morning care.Review of the April 2026 Treatment Administration Record revealed the above order to apply the bilateral hand splints was signed off as completed on 4/8/2026 by LPN, Staff H. During a surveyor observation on 4/8/2026 at 11:50 AM, Resident ID #52 did not have his/her hand splints on, as they were observed to be in his/her top drawer.During a surveyor interview immediately following the above observation, Staff H acknowledged that the resident was not wearing his/her bilateral hand splints, as ordered, and acknowledged that she had signed as completed in the TAR, indicating the resident was wearing them. During a surveyor interview on 4/10/2026 at approximately 1:30 PM with the DNS, she revealed that she would expect staff to follow all physician's orders and to sign on treatment orders after they had been completed.3. Record review revealed Resident ID #71 was readmitted to the facility in December of 2024 with a diagnosis including, but not limited to, anoxic brain damage. Further record review revealed the resident has a G-tube.Record review revealed a physician's order dated 1/23/2025, to flush the G-tube with 30 ML of water prior to feeding and flush with 30 ML after each feeding.Review of the February, March, and April 2026 Treatment/Medication Administration Records<br>(continued on next page) |

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| Coventry Operations RI LLC Dba Respiratory and Reh | 10 Woodland Drive<br>Coventry, RI 02816 |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | revealed the above order to flush the resident's G-tube before and after feedings was signed as completed each shift. Further review revealed inconsistent documented fluid totals for every shift, which include 640 ML, 150 ML, and 60 ML.During a surveyor interview on 4/8/2026 at 10:35 AM, with LPN, Staff H, she revealed that she signed the above flushing order on 4/7 and 4/8/2026 and revealed that she documented 60 ML because she calculates 30 ML for each flush and revealed that she was unclear why other staff are documenting other amounts.During a surveyor interview on 4/10/2026 at 9:51 AM, with the DNS, she revealed that she would have expected staff to clarify the physician's order and document accurately. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>Based on surveyor observation, clinical record review, and staff interviews, the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infection, relative to maintaining Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities) for 1 of 1 resident observed on EBP, Resident ID #20. Additionally, the facility failed to maintain contact/droplet precautions (an infection control measure that is used when a resident is known or expected to be infected to prevent the spread of germs that can be transmitted through respiratory droplets expelled when a person coughs, sneezes, or speak) for 3 of 3 residents observed on contact/droplet precautions, Resident ID #s 41, 87, and 107.Findings are as follows:Review of the Center for Disease Control and Prevention document titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDROs) Last Reviewed: August 1, 2023, states in part, Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing .MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities .The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents .with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include.Device care or use of a device [i.e that is].feeding tubes.Review of the facility policy titled Infection Control Policies and Procedures dated 12/16/2024, states in part .Signage at the entry of the patient's room shall indicate the type of precautions to use and the type of personal protective equipment [PPE] that is required upon entry.1. Record review revealed Resident ID #20 was admitted to the facility in January of 2024 with a diagnosis including but not limited to anoxic brain damage (occurs when the brain is completely deprived of oxygen, leading to brain cell death). Further review revealed that s/he has a gastrotomy tube (gtube, a medical device inserted through the abdomen directly into the stomach to provide long-term nutritional support, fluids, and medication).During a surveyor observation of signage posted at the resident's doorway on 4/6/2026 at approximately 11:50 AM stated in part, Enhanced Barrier Precautions.Providers and staff must also: wear gloves and a gown for the following High-Contact Resident Care Activities.Device care or use.feeding tube.During a surveyor observation on 4/6/2026 at 11:53 AM, Registered Nurse (RN), Staff X, was observed flushing the resident's G-tube without wearing a gown, as required.During a surveyor interview immediately following the above-mentioned observation with Staff X, she acknowledged that she did not wear a gown when she flushed the resident's G-tube.2. Record review revealed Resident ID #87 was admitted to the facility in September of 2025 with a diagnosis including, but not limited to, acute respiratory failure with hypoxia (a life-threatening emergency when there is not enough oxygen in the blood).Record review of a physician's order dated 4/8/2026 revealed the resident was on contact/droplet precautions for Respiratory Syncytial Virus (RSV; a highly contagious respiratory virus).During a surveyor observation of signage posted at the resident's doorway on 4/8/2026 at approximately 8:00 AM stated in part, Special Contact and Droplet Precautions.wear face shield.upon entering.A. During the medication administration task on 4/8/2026 at 8:13 AM, with RN, Staff Y, she entered Resident ID #87's room to administer his/her medication without a face shield, as indicated on the signage posted.During a surveyor interview immediately following the above-mentioned observation with Staff Y, she acknowledged that she did not wear a face shield prior to entering the room. B. During a surveyor observation on 4/8/2026 at 11:42 AM, Nursing Assistant (NA), Staff Z, was observed in Resident ID #87's room only wearing a gown and mask and not wearing a face shield and gloves, as required. Staff Z then exited the room wearing the same gown, he did not perform hand hygiene, removed<br>(continued on next page) |

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| Coventry Operations RI LLC Dba Respiratory and Reh | 10 Woodland Drive<br>Coventry, RI 02816 |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | gloves from a bin that stored clean PPE outside of the room, and reentered the resident's room without wearing a face shield.During a surveyor interview immediately following the above-mentioned observation with Staff Z, he acknowledged that he did not wear the appropriate PPE, as required.3. Record review revealed Resident ID #41 was admitted to the facility in August of 2025 with a diagnosis including, but not limited to, adult failure to thrive.Record review of a physician's order dated 4/8/2026 revealed the resident was on contact/droplet precautions for RSV.During a surveyor observation of signage posted at the resident's doorway on 4/8/2026 at approximately 9:00 AM stated in part, Special Contact and Droplet Precautions.wear an N95 Respirator, gown, face shield, and gloves.upon entering.During a surveyor observation on 4/8/2026 at 9:03 AM, NA, Staff B, was observed in the resident's room wearing only a mask and gloves and was not wearing a gown and face shield, as indicated on the signage posted.During a surveyor interview immediately following the above-mentioned observation with Staff B, she acknowledged that she did not wear a gown and face shield prior to entering the room. 4. Record review revealed Resident ID #107 was admitted to the facility in February of 2025 with diagnoses including, but not limited to, acute respiratory failure and tracheostomy (a surgically opening created in the neck leading directly into the windpipe to establish an airway using a tube).Record review of a physician's order dated 4/8/2026 revealed the resident is on contact/droplet precautions for RSV.During a surveyor observation of signage posted at the resident's doorway on 4/9/2026 at 8:18 AM revealed s/he is only on Contact Precautions.During a surveyor observation on 4/9/2026 at 9:33 AM in the presence of the Infection Preventionist (IP), she acknowledged the resident was on contact/droplet precautions for RSV and acknowledged the signage posted was inaccurate.During interviews with the Infection Preventionist (IP) on 4/9/2026, at 11:39 AM and 4/10/2026 at approximately 1:00 PM, she stated that staff are expected to adhere to the posted signage at residents' doorways, including donning the required PPE prior to entering any room on precautions. During surveyor interviews on 4/10/2026 at 1:00 PM and 1:30 PM with the Director of Nursing Services, she was unable to provide evidence that infection control practices were maintained by the above staff, as required. |

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| F 0940<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop, implement, and/or maintain an effective training program for all new and existing staff members.<br><br>Based on record review and staff interview, the facility failed to develop, implement, and maintain an effective training program for annual training for existing employees consistent with their expected roles, relative to education per the facility assessment, for 10 of 11 employees reviewed, Staff I, J, K, L, M, T, Y, GG, HH, and II.Findings are as follows:Record review of the Facility Assessment, dated March 2026, states in part, .We utilize Health Stream services for increased/mandatory education on annual and quarterly bases.Staff competencies required.A full ledger of staff-specific courses/competencies can be found in Health Stream.Record review of the facility's Health Stream Annual Education Plan revealed the following required trainings:-Resident rights and abuse prevention-HIPAA (Health Insurance Portability and Accountability Act) and confidentiality-Corporate compliance and ethics-Safe resident handling and transfers-Fall prevention-Emergency preparedness-Skin integrity and pressure injury prevention-Pain assessment and management-Dementia and behaviors-Mental health management-Food safety and sanitation-Nutrition, hydration, and dysphagia care-Effective communication-Culturally competent care-Trauma informed care-Ethics in health careRecord review revealed Unit Manager, Licensed Practical Nurse (LPN), Staff T, was hired on 9/9/2024. A review of his record from 2025 to 2026 failed to reveal evidence that he completed the mandatory required trainings including; resident rights and abuse prevention; corporate compliance and ethics; safe resident handling and transfers; emergency preparedness; skin integrity and pressure injury prevention; pain assessment and management; dementia and behaviors; mental health management; food safety and sanitation; nutrition, hydration, and dysphagia care; effective communication; culturally competent care; trauma informed care; and ethics in health care.Record review revealed LPN, Staff Y, was hired on 5/16/2017. A review of her record from 2025 to 2026 failed to reveal evidence that she completed the mandatory required trainings including: corporate compliance and ethics; mental health management; food safety and sanitation; nutrition, hydration, and dysphagia care; effective communication; culturally competent care; trauma informed care; and ethics in health care.Record review revealed Respiratory Therapist, Staff GG, was hired on 1/20/2022. A review of her record from 2025 to 2026 failed to reveal evidence that she completed the mandatory required trainings including: safe resident handling and transfers; skin integrity and pressure injury prevention; pain assessment and management; dementia and behaviors; food safety and sanitation; nutrition, hydration, and dysphagia care; and culturally competent care.Record review revealed Nursing Assistant (NA), Staff K, was hired on 1/21/2025. A review of his record from 2025 to 2026 failed to reveal evidence that he completed the mandatory required trainings including: resident rights and abuse prevention; corporate compliance and ethics; safe resident handling and transfers; emergency preparedness; skin integrity and pressure injury prevention; pain assessment and management; dementia and behaviors; mental health management; food safety and sanitation; nutrition, hydration, and dysphagia care; effective communication; culturally competent care; trauma informed care; and ethics in health care.Record review revealed NA, Staff M, was hired on 7/11/2024. A review of her record from 2025 to 2026 failed to reveal evidence that she completed the mandatory required trainings including: corporate compliance and ethics; safe resident handling and transfers; skin integrity and pressure injury prevention; pain management; mental health management; nutrition, hydration, and dysphagia care, and effective communication.Record review revealed NA, Staff I, was hired on 3/15/2000. A review of her record from 2025 to 2026 failed to reveal evidence that she completed the mandatory required trainings including: corporate compliance and ethics; safe resident handling and transfers; skin integrity and pressure injury prevention; pain management; mental health management; nutrition, hydration, and dysphagia care.Record review revealed NA, Staff J, was hired on 11/11/2013. A review of her record from 2025 to 2026 failed to reveal evidence that she completed the mandatory<br>(continued on next page) |

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| F 0940<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | required trainings including: corporate compliance and ethics; safe resident handling and transfers; skin integrity and pressure injury prevention; pain assessment and management; mental health management; nutrition, hydration, and dysphagia care.Record review revealed NA, Staff L, was hired on 3/29/2001. A review of her record from 2025 to 2026 failed to reveal evidence that she completed the mandatory required training including: HIPAA and confidentiality; corporate compliance and ethics; safe resident handling and transfers; emergency preparedness; skin integrity and pressure injury prevention; pain management; dementia and behaviors; mental health management; food safety and sanitation; nutrition, hydration, and dysphagia care; effective communication; culturally competent care; trauma informed care; and ethics in health care.Record review revealed Medication Aide (MA), Staff HH, was hired on 1/26/2005. A review of her record from 2025 to 2026 failed to reveal evidence that she completed the mandatory required trainings including: corporate compliance and ethics; safe resident handling and transfers; emergency preparedness; skin integrity and pressure injury prevention; dementia and behaviors; mental health management; food safety and sanitation; nutrition, hydration, and dysphagia care; effective communication; culturally competent care; trauma informed care; and ethics in health care.Record review revealed (MA), Staff II, was hired on 10/27/2003. A review of her record from 2025 to 2026 failed to reveal evidence that she completed the mandatory required trainings including: corporate compliance and ethics; skin integrity and pressure injury prevention; mental health management; and nutrition, hydration, and dysphagia care.During a surveyor interview on 4/10/2026 at 1:11 PM with the Administrator, he indicated that he would expect all trainings that are outlined in the facility assessment to be completed by staff. Additionally, he was unable to provide evidence that the above-mentioned staff received the required annual education and training, per the facility assessment. |

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| | 415078 | A. Building<br>B. Wing | 04/14/2026 |

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| Coventry Operations RI LLC Dba Respiratory and Reh | 10 Woodland Drive<br>Coventry, RI 02816 |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to ensure that the resident's formulated advance directive would be followed, as there were inconsistencies between the paper medical record and the Electronic Medical Record (EMR), for 1 of 1 resident reviewed who had recently changed his/her code status, Resident ID #4. Findings are as follows:Record review revealed the resident was re-admitted to the facility in April of 2025 with diagnoses including, but not limited to, end stage renal disease (the final stage of kidney failure) and dependence on renal dialysis (a life sustaining treatment that filters waste, toxins, and excess fluids from the blood when the kidneys have failed).Record review of the EMR advance directive banner, indicates a code status of Do Not Resuscitate (DNR)/Comfort Measures Only (CMO). Further review revealed a physician's order dated [DATE] indicating a code status of DNR/CMO. Record review of the most recent Medical Order for Life Sustaining Treatment (MOLST) document, dated [DATE] signed by the provider and the resident, indicates that the resident has a code status to attempt resuscitation/cardiopulmonary resuscitation (CPR). Record review of a provider progress note dated [DATE] indicates that the resident requested to speak to the provider to re-evaluate his/her advance care planning related to his/her code status and that s/he changed his/her mind from wanting to be a DNR to a Full Code. During a surveyor interview on [DATE] at 11:29 AM with the Unit Manager, Licensed Practical Nurse, Staff F, she revealed that the resident's EMR indicates the resident's code status is DNR/CMO. She acknowledged that the most recent signed MOLST indicates to attempt CPR, and that DNR is not indicated. Additionally, she revealed that she would initially refer to the EMR for the resident's code status in the event of an emergency, which would have indicated DNR.During a surveyor interview on [DATE] at 1:12 PM with the Physician Assistant, Staff G, he indicated that he spoke with the resident about his/her code status in February, because the resident had changed his/her mind and no longer wanted a code status of DNR, s/he wanted to be a full code. Staff G acknowledged that the MOLST document dated [DATE], is the resident's most up to date code status. |

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| | 415078 | A. Building<br>B. Wing | 04/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Coventry Operations RI LLC Dba Respiratory and Reh | 10 Woodland Drive<br>Coventry, RI 02816 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>Based on surveyor observation, clinical record review, and staff interviews, the facility failed to ensure that a resident receives care, consistent with professional standards of practice, to promote wound healing for 1 of 1 resident reviewed with actual pressure ulcers (localized injuries to the skin and/or underlying skin usually over a bony prominence), Resident ID #52.Findings are as follows:Record review revealed the resident was admitted to the facility in March of 2021 with diagnoses including, but not limited to, anoxic brain damage (caused by a lack of oxygen to the brain) and persistent vegetative state. Record review of a nursing progress note dated 4/8/2026 at 5:53 PM, revealed that resident has a new Stage 1 pressure injury to the dorsum (area of the foot on the top surface extending from the ankle to the toes) of his/her right foot.Review of a care plan last revised on 3/5/2026 revealed the resident is at risk for skin breakdown with interventions including, but not limited to, off loading and floating heels with pillows while in bed.Record review of a physician's order dated 5/24/2021 indicated to float heels while in bed. Record review of a physician's order dated 4/8/2026 revealed to offload bilateral heels and feet with pillows at all times, as tolerated, every shift.During surveyor observations on 4/10/2026, at the following times, the resident had his/her heels and feet resting directly on the mattress:-10:16 AM-12:16 PMDuring a surveyor interview on 4/10/2026 at 12:23 PM with the Unit Manager, Staff A, she acknowledged that the resident has a new pressure injury to his/her right foot and s/he has physician's orders to offload his/her heels at all times. During this interview she acknowledged that the resident had his/her feet resting directly on the mattress.During a surveyor interview on 4/10/2026 at approximately 1:30 PM with the Director of Nursing Services, she revealed that she would expect staff to follow all physician's orders. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, and staff interviews, the facility failed to ensure a resident with limited range of motion (ROM) receives appropriate treatment and services to increase ROM and/or to prevent further decrease in ROM for 1 of 2 residents reviewed with contractures (the shortening of muscles, tendons, skin, and nearby soft tissues that cause the joints to become very stiff, which prevents normal movement), Resident ID #52.Findings are as follows:Record review revealed Resident ID #52 was admitted to the facility in March of 2021 with diagnoses including, but not limited to, anoxic brain damage (caused by a lack of oxygen to the brain) and persistent vegetative state. Record review of a Minimum Data Set Assessment (MDS) dated [DATE] revealed the resident was in a persistent vegetative state with no discernible consciousness. Further review revealed the resident had impaired range of motion to both of his/her upper extremities. Additional review revealed that the resident is dependent on staff for activities of daily living (ADLs). Record review of an Occupational Therapy (OT) Discharge summary dated [DATE], revealed the resident has contractures to his/her right and left hands. Discharge recommendations include a splint/brace to both hands after morning care.Record review of a physician's order dated 10/13/2022 revealed bilateral hand splints to be applied after morning care.Review of a care plan last revised on 4/19/2022 revealed the resident is dependent on staff for ADLs with interventions including, but not limited to, bilateral splints to be applied in the morning and removed in the afternoon/evening as tolerated.During surveyor observations on the following dates and times, the resident did not have his/her bilateral hand splints on:-4/6/2026 at 9:58 AM-4/6/2026 at 11:59 AM-4/7/2026 at 8:58 AM -4/7/2026 at 9:58 AM -4/8/2026 at 9:58 AM -4/8/2026 at 10:59 AM -4/8/2026 at 11:50 AMDuring the above surveyor observations from 4/6/2026 through 4/8/2026 the resident's bilateral hand splints could be seen in the top drawer of his/her nightstand. Record review of the April 2026 Treatment Administration Record revealed an order dated 10/13/2022 for bilateral hand splints to be applied after morning care. This order was signed by staff as being completed daily from 4/1/2026 through 4/8/2026.During a surveyor interview on 4/8/2026 at 11:53 AM with Licensed Practical Nurse, Staff H, she acknowledged that the resident was not wearing his/her bilateral hand splints. She further acknowledged that she signed that the treatment was completed.Record review revealed a new physician's order dated 4/9/2026 for bilateral hand splints to be applied after morning care as tolerated in the morning. This order was created after the above observations and interview.During a surveyor interview on 4/10/2026 at approximately 1:30 PM with the Director of Nursing Service, she revealed that she would expect staff to follow all physician's orders and to sign treatment orders after the treatment was completed. |

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| F 0568<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.<br><br>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 6 of 6 residents reviewed, Resident ID #s 14, 55, 57, 71, 74, and 86.Findings are as follows:Record of a facility document titled Resident Fund Management Service balance report as of 4/8/2026, revealed that the facility holds funds for Resident ID #s 14, 55, 57, 71, 74, and 86.Record review failed to reveal evidence quarterly statements were provided to Resident ID #s 14, 55, 57, 71, 74, and 86.During a surveyor interview on 4/8/2026 at 10:19 AM, with the Regional Business Office Assistant, she was unable to provide evidence of a written accounting of the above residents' deposits, withdrawals, and balances at least quarterly, per the regulation.During a surveyor interview on 4/10/2026 at 12:40 PM, with the Administrator, he was unable to provide evidence that the facility provided quarterly statements for the above-mentioned residents within the last four quarters, as required. |

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| F 0569<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.<br><br>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 with over $4000 in personal needs funds handled by the facility, Resident ID #s 14 and 74. Findings are as follows: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, ICF/DD Facilities, and Assisted Living Residences requires that the facility shall: .(10) 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 .Balances as of 4/8/2026 for the following residents states in part:-Resident ID #14 has a current balance of $5,522.21.-Resident ID #74 has a current balance of $4,118.71.During a surveyor interview on 4/8/2026 at 10:19 AM, with the Regional Business Office Assistant, she was unable to provide evidence that Resident ID #s 14 and 74 were notified in writing when their account balances reached $200 less than the SSI Medicaid eligibility resource limit ($4,000). |

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| F 0573<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Let each resident or the resident's legal representative access or purchase copies of all the resident's records.<br><br>Based on record review and staff interviews, the facility failed to allow the resident or resident representative to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility relative to 1 of 1 resident reviewed whose resident representative requested his/her medical records, Resident ID #120.Findings are as follows:Record review of a community reported complaint submitted to the Rhode Island Department of Health on 3/11/2026 alleges, in part, that the facility failed to provide Resident ID #120's medical records to a family member who asserted legal entitlement to access the records as the resident's heir-at-law.Record review revealed the resident resided in the facility from September of 2025 until s/he passed away in the facility in October of 2025.Record review revealed a document titled, Consent for the Release of Confidential Health Care Information dated 1/5/2026 which revealed the family member's formal request for the resident's record. Additional record review indicated the consent was sent via certified mail and received by the facility on 1/7/2026.During a surveyor interview with the facility's Medical Records Manager on 4/8/2026 at 9:48 AM, she indicated that she received the request for the resident's medical records in January of 2026. She further revealed that she sent the records to the facility's lawyer via email, and she was unaware if the resident's representative had received them.Record review of the above-mentioned email thread revealed the resident's electronic medical records were sent to the facility's lawyer as of 2/17/2026. Further review of this email thread did not indicate that the resident's medical records were then sent to the resident's representative or their lawyer.During a surveyor interview with the resident's representative on 4/8/2026 at 1:34 PM, s/he indicated that s/he had requested his/her family member's medical records to be sent to him/her electronically in January of 2026. Additionally, s/he indicated that over the past 3 months, s/he has called the facility numerous times, has sent multiple emails and has not yet received his/her family member's medical records.On 4/9/2026 at 9:52 AM, the surveyor left a voicemail for the facility's lawyer regarding the above matter, however, the lawyer did not return the surveyor's call.During a surveyor interview on 4/9/2026 at 1:49 PM with a Paralegal of the resident's representative's lawyer, she indicated that the law firm has not received any of Resident ID #120's medical records.During a surveyor interview with the Administrator on 4/9/2026 at 2:08 PM, he was unable to provide evidence that the resident's representative was provided a copy of the resident's medical records with 2 working days advance notice, as required. |