STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Health and Rehabilitation Center	4 St Joseph Street Woonsocket, RI 02895

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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 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50004 Based on surveyor observation, resident, and staff interview, it has been determined that the facility failed to ensure a safe environment was maintained relative to unsafe water temperatures, for 4 of 4 floors observed. Findings are as follows: According to the State Operation Manual Appendix PP- Guidance to Surveyors for Long Term Care Facilities, last revised 8/8/2024, states in part, .Some States have regulations regarding allowable maximum water temperature .Water may reach hazardous temperatures in hand sinks, showers, tubs, and any other source or location where hot water is accessible to a resident. Burns related to hot water/liquids may also be due to spills and/or immersion .skin in relation to the temperature of the water and the length of time of exposure .Time Required for a 3rd Degree Burn to Occur .133 F, 15 seconds . According to TITLE 216 - DEPARTMENT OF HEALTH, CHAPTER 40 - PROFESSIONAL LICENSING AND FACILITY REGULATION, SUBCHAPTER 10 - FACILITIES REGULATION, PART 1 - Licensing of Nursing Facilities, .In resident areas, hot water temperatures shall not be less than one-hundred degrees Fahrenheit (100 F) nor exceed one-hundred- and eighteen-degrees Fahrenheit (118 F). Thermometers [accuracy of which can be plus or minus two degrees Fahrenheit (+/-2 F)] shall be provided in each residential area to check water temperature periodically on that unit and at each site where residents are immersed or showered . Record review of a facility document titled, Water Temperatures, states in part, Resident hot water usage temperature will be kept at a level of not less than 100 degrees Fahrenheit nor exceed 118 degrees Fahrenheit per State regulations .Maintenance personnel shall monitor equipment and water supply sources to ensure that malfunctions are not occurring .Water temperatures are to be monitored not less than weekly with the following: Maintenance personnel will take water temperatures weekly with random sample . Maintenance shall provide thermometers to each unit for nursing personnel to periodically check water temperatures on their unit and where residents are immersed or showered .In the event that a non-maintenance staff member discovers a temperature out of the range (note that the range may include a plus/minus two degrees) or by touch feels that the temperature is too high or low, maintenance will be notified . (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 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a surveyor observation on 2/24/2025 at approximately 9:33 AM on the 1st Floor, a surveyor was washing their hands in resident room [ROOM NUMBER]'s sink. The water became very hot to touch, reddening the skin of the surveyor's hands, and steam was rising from the sink. Following this observation, the water temperature was obtained using a digital thermometer and recorded a temperature of 137.5 F. During surveyor observations on 2/24/2025, immediately following the above observation, water temperatures were obtained and were found to exceed 120 degrees F: Ground Floor: -Shower room, shower 132.0 F -Resident room [ROOM NUMBER], sink 136.5 F -Resident room [ROOM NUMBER], sink 137.1 F First Floor: -Resident room [ROOM NUMBER], sink 137.1 F -Resident room [ROOM NUMBER], sink 137.7 F -Resident room [ROOM NUMBER], sink 137.5 F Second Floor: -Resident room [ROOM NUMBER], sink 137.5 F -Resident room [ROOM NUMBER], sink 133.3 F -Resident room [ROOM NUMBER], sink 133.7 F Third Floor: -Shower room, sink 133.9 F -Resident room [ROOM NUMBER], sink 135.5 F -Resident room [ROOM NUMBER], sink 136.0 F -Resident room [ROOM NUMBER], sink 133.0 F During a surveyor interview on 2/24/2025 at 9:50 AM with Nursing Assistant, Staff L, regarding the 2nd floor shower room, she acknowledged that the staff use both showers in the shower room for residents daily and stated, I don't want it to get too hot, so I only turn it up halfway. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a surveyor interview on 2/24/2025 at approximately 10:08 AM with NA, Staff M, she revealed that at times the water can get too hot. During a surveyor interview on 2/24/2025 at approximately 11:05 AM with Resident ID #9, s/he revealed that the maintenance staff recently fixed the hot water in his/her room sink and now it does not have any cold water. The resident further revealed that s/he could not use it because the water is too hot. During a surveyor interview and observation on 2/24/2025 at approximately 10:40 AM, with the Maintenance Director, the following water temperatures were obtained and found to exceed 120 degrees F: Ground floor: Resident room [ROOM NUMBER], sink 133.1 F First Floor: Resident room [ROOM NUMBER], sink 132.8 F Second Floor: Resident room [ROOM NUMBER], sink 132.8 F Third Floor: Resident room [ROOM NUMBER], sink 131.0 F During a surveyor interview immediately following the above observation with the Maintenance Director, he acknowledged the above water temperatures exceeded 120 F. During a surveyor interview on 2/24/2025 at approximately 11:21 AM, with the Administrator in the presence of the Director of Nursing Services, she acknowledged that water temperatures should not exceed 120 F. Additionally, they were unable to provide evidence that the facility to ensure a safe environment was maintained, relative to water temperatures. The facility's failure to ensure safe water temperatures throughout the facility placed the residents at risk for serious injury, serious harm, serious impairment or death.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 46241 Based on record review and staff interview, it has been determined that the facility failed to ensure that they not employ or otherwise engage individuals who have been found guilty of abuse or mistreatment by a court of law, for 1 of 1 personnel record reviewed for disqualifying information, Maintenance Assistant, Staff A. Findings are as follows: Review of a facility policy titled, Abuse prohibition states in part, .DEFINITIONS: Abuse: Willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish and included physical, verbal, sexual, and mental abuse .Any person seeking employment at this facility (which involves routine contact with a resident without the presence of other employees) shall be subject to a criminal background check, which is to initiated .The employee, through the employer, shall apply to the bureau of criminal identification [BCI] of the state or local police department for a statewide criminal records check .If the facility receives notice of disqualifying information regarding the employee, said employee will be disqualified from employment . Record review revealed Staff A was hired on 1/27/2025 as a Maintenance Assistant. Review of a document titled MAINTENANCE DEPT WEEKLY SCHEDULE revealed Staff A works at the facility Monday through Friday from 8:30 AM to 4:30 PM. It further revealed that he is on call during the fourth weekend of the month. Review of a BCI dated 1/21/2025 states in part, As mandated by both federal and state law, the fingerprints of [Staff A] .were processed to determine if they have a criminal record containing disqualifying information. The results of their fingerprint based Comprehensive Criminal Background check shows that they HAVE DISQUALIFYING INFORMATION as delineated under federal and state law . Further review of the BCI revealed a handwritten note which states [Administrator] aware. Review of a document titled, Case Summary filed on 4/14/2022 and closed on 4/6/2023 revealed, Staff A plead Nolo Contendere (when someone uses this phrase in a court setting, they are saying they do not wish to fight the charges against them. This plea is a way for a defendant to accept the consequences of their actions without admitting guilt) to the following charges and was convicted by a court of law: - Domestic violence - simple assault (an intentional act that causes another person to fear imminent harmful or offensive contact, or causes minor bodily injury) and/or battery (unlawful physical contact), 1st offense - Domestic violence - disorderly conduct, 1st offense (continued on next page)

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 2/25/2025 at 2:31 PM with Administrator, in the presence of the Director of Nursing Services, she revealed that Staff A was hired at the end of January, and has since completed orientation, and is working independently on the 2nd floor as the team leader. She revealed that he was forthcoming with his disqualifying information on his BCI and indicated that when she spoke with him, he informed her that he had a domestic incident on his record. She revealed that she was under the impression, after speaking with him, that the charges were dismissed. During a surveyor interview on 2/27/2025 at 8:08 AM, with the Administrator, she revealed that she had met with Staff A the previous night, and he indicated to her that he was under the impression the charges were resolved because he had completed all sentencing components, including probation and therapeutic services. She further revealed that he did go to court on 2/26/2024 and provided documentation which revealed he was charged and convicted of the crimes. Additionally, she revealed that he has not been back to the facility since this concern was identified by the surveyor and brought to the facility's attention and that a decision regarding his employment has not been determined.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37158 46118 46241 46539 48928 50004 Based on record review and staff interview, it has been determined that the facility failed to ensure that the assessment accurately reflected the resident's status for 2 of 2 residents reviewed for dialysis (a type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to.), Resident ID #s 35 and 137, 1 of 2 residents reviewed for elopement, Resident ID #161, 1 of 2 residents reviewed for wounds infected with a Multidrug Resistant Organism (MDRO), Resident ID #83 and 1 of 2 closed records reviewed, Resident ID #169. Findings are as follows: 1. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual last revised in October 2024 states in part, .Code peritoneal or renal dialysis which occurs at the nursing home or at another facility . 1a. Record review revealed Resident ID #35 was admitted to the facility in July 2018 with a diagnosis including, but not limited to, diabetes mellitus. Review of a Minimum Data Set (MDS) assessment dated [DATE], Section O, titled, Special Treatments, Procedures, and Programs revealed the resident was checked off for receiving dialysis while a resident during the 7-day look-back period. Record review failed to reveal evidence that Resident ID #35 was receiving dialysis treatments. 1b. Record review revealed Resident ID #137 was readmitted to the facility in October 2024 with diagnoses including, but not limited to, dependence on renal dialysis and end stage renal disease. Record review of a care plan last revised 5/20/2024 revealed that Resident ID #137 requires dialysis related to renal failure. Review of a physician's order dated 10/17/2024 revealed that Resident ID #137 receives dialysis 3 days per week. Review of a MDS assessment dated [DATE], Section O, titled, Special Treatments, Procedures, and Programs revealed the resident was not checked off for dialysis while a resident during the 7-day look-back period. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual last revised in October 2024 states in part, Identify all alarms that were used at any time (day or night) during the 7-day look-back period, code the frequency of use: Code 0, not used: if the device was not used during the 7-day look-back period. Code 1 used less than daily .Code 2, used daily .Wander/elopement alarm includes devices such as bracelets [wander guard] .that activate an alarm and/or alert the staff when the resident nears or exits . Record review revealed Resident ID #161 was admitted to the facility in October 2024 with a diagnosis including, but not limited to, dementia. Record review revealed the following physician's orders: -10/30/2024 Check wander guard functionality every night for safety. -10/30/2024 Check wander guard placement location-left wrist every shift. -1/27/2025 Wander guard expires 2/24/2026. Record review of the January and February 2025 Medication Administration Report revealed the above orders were signed off as completed daily from 1/30/2025 through 2/5/2025. Review of a MDS assessment dated [DATE], Section P, titled, Alarms revealed the resident was not coded for the use of a wander guard during the 7-day look-back period. 3. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual last revised in October 2024 states in part, Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period . Record review revealed Resident ID #83 was admitted to the facility in December of 2023 with a diagnosis including, but not limited to, methicillin-resistant Staphylococcus aureus (MRSA is a MDRO that causes infections in different parts of the body). Record review revealed that Resident ID #83 tested positive for MRSA in his/her leg wound on 3/4/2024. Record review revealed that Resident ID #83's leg wound tested positive again for MRSA in November of 2024. Review of a MDS assessment dated [DATE], Section I, titled, Active Diagnoses in the Last 7 Days revealed the resident was not coded for having an active diagnosis of an MDRO. 4. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual last revised in October 2024 states in part, Review the medical record including the discharge plan and discharge orders for documentation of discharge location . (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed Resident ID #169 was admitted to the facility in January of 2025 with diagnoses including, but not limited to, status post fall and pain. Record review of a nursing progress note dated 1/27/2025 revealed that Resident ID #169 was discharged home with services on 1/27/2025. Review of a MDS assessment dated [DATE], Section A, titled, Discharge Status revealed the resident was coded for a planned discharge to the hospital. During a surveyor interview on 2/27/2025 at 11:04 AM, with the MDS Coordinator, she revealed that the MDS assessments for Resident ID #s 35, 83, 137, 161 and 169 were coded in error and would be modified with the correct information after being brought to the facility's attention by the surveyor. During a surveyor interview on 2/27/2025 at 2:42 PM, with the Administrator, she acknowledged that the above MDS assessments for Resident ID #s 35, 83, 137, 161 and 169 were coded inaccurately.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 37158 46118 Based on record review and staff interview, it has been determined that the facility failed to review and revise the resident's care plan by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments relative to 29 of 29 long term care residents reviewed, Resident ID #s, 3, 5, 6, 9, 10, 15, 21, 22, 23, 25, 29, 35, 38, 44, 67, 70, 75, 78, 83, 88, 95, 123, 129, 137, 139, 140, 142, 161, and 520. Findings are as follows: 1. Record review revealed Resident ID #3 was originally admitted to the facility in May of 2024 with diagnoses including, but not limited to, diabetes mellitus type 2 and chronic heart failure. Record review revealed the most recent Quarterly Minimum Data Set (MDS) Assessment was completed on 12/17/2024. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. 2. Record review revealed Resident ID #5 was originally admitted to the facility in September of 2025 with diagnoses including, but not limited to, diabetes mellitus type 2 and chronic pain. Record review revealed the most recent Quarterly MDS Assessment was completed on 1/17/2025. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. 3. Record review revealed Resident ID #6 was originally admitted to the facility in December of 2022 with diagnoses including, but not limited to, anxiety disorder and high blood pressure. Record review revealed the most recent Quarterly MDS Assessment was completed on 1/25/2025. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. 4. Record review revealed Resident ID #9 was admitted to the facility in February of 2011 with diagnoses including, but not limited to, epilepsy and dementia. Record review revealed the most recent Quarterly MDS Assessment was completed on 12/14/2024. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Record review revealed Resident ID #10 was admitted to the facility in June of 2021 with diagnoses including, but not limited to, repeated falls and pulmonary infection. Record review revealed the most recent Quarterly MDS Assessment was completed on 12/23/2024. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. 6. Record review revealed Resident ID #15 was originally admitted to the facility in November of 2019 with diagnoses including, but not limited to, diabetes mellitus type 2 and muscle weakness. Record review revealed the most recent Quarterly MDS Assessment was completed on 12/18/2024. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. 7. Record review revealed Resident ID #21 was originally admitted to the facility in February of 2022 with diagnoses including, but not limited to, heart failure and acute respiratory failure. Record review revealed the most recent Quarterly MDS Assessment was completed on 12/26/2024. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. 8. Record review revealed Resident ID #22 was originally admitted to the facility in February of 2024 with diagnoses including, but not limited to, dementia and acute respiratory failure. Record review revealed the most recent Comprehensive MDS Assessment was completed on 12/16/2024. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the comprehensive assessment. 9. Record review revealed Resident ID #23 was originally admitted to the facility in July of 2024 with diagnoses including, but not limited to, seizures and dementia. Record review revealed the most recent Quarterly MDS Assessment was completed on 2/5/2025. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. 10. Record review revealed Resident ID #25 was readmitted to the facility in June of 2024 with diagnoses including, but not limited to, seizures and a history of falling. Record review revealed the most recent Quarterly MDS Assessment was completed on 2/3/2025. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. Record review revealed Resident ID #29 was originally admitted to the facility in March of 2021 with diagnoses including, but not limited to, kidney failure and dementia. Record review revealed the most recent Comprehensive MDS Assessment was completed on 1/14/2025. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the comprehensive assessment. 12. Record review revealed Resident ID #35 was originally admitted to the facility in July of 2018 with diagnoses including, but not limited to, diabetes mellitus type 2 and epilepsy. Record review revealed the most recent Quarterly MDS Assessment was completed on 1/29/2025. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. 13. Record review revealed Resident ID #38 was originally admitted to the facility in April of 2023 with diagnoses including, but not limited to, diabetes mellitus type 2 and end stage renal disease (kidney disease). Record review revealed the most recent Quarterly MDS Assessment was completed on 12/9/2024. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. 14. Record review revealed Resident ID #44 was originally admitted to the facility in December of 2020 with diagnoses including, but not limited to, diabetes mellitus and chronic obstructive pulmonary disorder (COPD). Record review revealed the most recent Quarterly MDS Assessment was completed on 1/22/2025. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. 15. Record review revealed Resident ID #67 was admitted to the facility in September of 2023 with diagnoses including, but not limited to, seizures and dementia. Record review revealed the most recent quarterly MDS Assessment was completed on 12/25/2025. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. 16. Record review revealed Resident ID #70 was originally admitted to the facility in November of 2023 with diagnoses including, but not limited to, COPD and muscle weakness. Record review revealed the most recent Quarterly MDS Assessment was completed on 2/1/2025. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. 17. Record review revealed Resident ID #75 was originally admitted to the facility in February of 2022 with diagnoses including, but not limited to, epilepsy and acute kidney failure. Record review revealed the most recent Quarterly MDS Assessment was completed on 1/17/2025. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. 18. Record review revealed Resident ID #78 was originally admitted to the facility in July of 2022 with diagnoses including, but not limited to, diabetes mellitus type 2 and seizures. Record review revealed the most recent Quarterly MDS Assessment was completed on 1/1/2025. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. 19. Record review revealed Resident ID #83 was originally admitted to the facility in December of 2023 with diagnoses including, but not limited to, acute kidney failure and difficulty walking. Record review revealed the most recent Comprehensive MDS Assessment was completed on 12/23/2024. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the comprehensive assessment. 20. Record review revealed Resident ID #88 was originally admitted to the facility in September of 2023 with diagnoses including, but not limited to, chronic kidney disease and post-traumatic stress disorder. Record review revealed the most recent Quarterly MDS Assessment was completed on 12/17/2024. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. 21. Record review revealed Resident ID # 95 was originally admitted to the facility in July of 2020 with diagnoses including, but not limited to, COPD and mood disorder. Record review revealed the most recent Quarterly MDS Assessment was completed on 2/5/2025. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. 22. Record review revealed Resident ID #123 was originally admitted to the facility in December of 2022 with diagnoses including, but not limited to, diabetes mellitus type 2 and dementia. Record review revealed the most recent Quarterly MDS Assessment was completed on 2/19/2025. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Health and Rehabilitation Center	4 St Joseph Street Woonsocket, RI 02895

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. 23. Record review revealed Resident ID #129 was originally admitted to the facility in October of 2022 with diagnoses including, but not limited to, dementia and muscle weakness. Record review revealed the most recent Quarterly MDS Assessment was completed on 12/24/2024. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. 24. Record review revealed Resident ID #137 was originally admitted to the facility in July of 2024 with diagnoses including, but not limited to, end stage renal disease (kidney disease) and altered mental status. Record review revealed the most recent Quarterly MDS Assessment was completed on 2/3/2025. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. 25. Record review revealed Resident ID #139 was originally admitted to the facility in September of 2023 with diagnoses including, but not limited to, repeated falls and pulmonary infection. Record review revealed the most recent Quarterly MDS Assessment was completed on 1/17/2025. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. 26. Record review revealed Resident ID #140 was admitted to the facility in October of 2023 with diagnoses including, but not limited to, dementia and COPD. Record review revealed the most recent Quarterly MDS Assessment was completed on 1/10/2025. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. 27. Record review revealed Resident ID #142 was admitted to the facility in July of 2024 with diagnoses including, but not limited to, dementia and protein-calorie malnutrition. Record review revealed the most recent Quarterly MDS Assessment was completed on 1/29/2025. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. 28. Record review revealed Resident ID #161 was admitted to the facility in October of 2024 with a diagnosis including, but not limited to, dementia. Record review revealed the most recent Quarterly MDS Assessment was completed on 2/5/2025. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the quarterly assessment. During a surveyor interview on 2/25/2025 at 8:19 AM, with Resident ID #161's family member, when asked by the surveyor if s/he attended the resident's care plan meetings, s/he revealed that s/he did not know what a care plan meeting was and indicated that s/he has never attended one. 29. Record review revealed Resident ID #520 was originally admitted to the facility in March of 2020 with diagnoses including, but not limited to, acute and chronic respiratory failure. Record review revealed the most recent Comprehensive MDS Assessment was completed on 1/19/2025. Record review failed to reveal evidence that the resident's care plan was reviewed and revised by the interdisciplinary team following the comprehensive assessment. During a surveyor interview with multiple residents, during the Resident Council task on 2/25/2025 at approximately 1:05 PM, they indicated that they were not typically involved in care plan meetings. During a surveyor interview on 2/27/2025 at 12:46 PM with MDS Nurse, Staff B, she indicated that care plan meetings are held quarterly to review and revise the care plans for every resident and that documentation of the meetings are kept in a binder or documented in the resident's progress notes. She indicated that a physician isn't typically included in the care plan meetings. Furthermore, she indicated that sometimes she needs to work on the floor and doesn't have time to hold the care plan meetings, as required. During a surveyor interview on 2/27/2025 at 1:03 PM with the Director of Nursing Services and the Administrator, they indicated that care plan meetings should be held quarterly. They further indicated that the Nursing Assistant's and the physicians aren't typically included in care plan meetings. Additionally, they could not provide evidence that the above mentioned residents' care plans were reviewed and revised, as required, by interdisciplinary team. 46241 46539 48928

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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. 37158 Based on record review and staff interview, it has been determined that the facility failed to ensure that services being provided meet professional standards of practice for 1 of 1 resident reviewed relative to Narcan administration, Resident ID #25, 2 of 6 residents reviewed for following physician orders relative to unnecessary medication, Resident ID #s 44 and 123, 1 of 1 resident seen by the podiatrist, Resident ID #78, 1 of 2 residents observed with a non-pressure wound, Resident ID #83 and 1 of 3 residents receiving a medication that requires blood levels to be monitored, Resident ID #95. Findings are as follows: 1. According to the facility policy titled Narcan Administration, states in part, .Policy: Narcan administration is for the occurrence of an opioid overdose. An opioid overdose is an acute condition in the case of excessive opioid use. Narcan should be administered in emergency cases of overdose . PROCEDURE: 1. An assessment for substance use disorder (SUD) will be done upon admission for each resident . 2. Consideration of a clinical overdose could include: use of opioids, known history of substance use disorder, slow or no breathing, gurgling, gasping or snoring, cool/clammy skin, cyanosis [bluish discoloration of the skin resulting from poor circulation or inadequate oxygenation] . 4. Attempt to verbally arouse the resident. Use a sternal rub if the resident is unconscious and is to be used prior to determining an opioid overdose . 7. Clinical Overdose is classified as having -a respiratory rate of 8-10 or lower per minute -inability to arouse/unconscious-pinpoint pupils . 9. If a resident meets criteria of clinical overdose, ensure there are 2 staff members present through the administration of Narcan 10. Procedure for initiating Narcan administration: -Call 911 and report possible overdose with plan to administer Narcan & retrieve crash/emergency cart . -Stay with resident until rescue arrives . Record review revealed Resident ID #25 was readmitted to the facility in June of 2024 with diagnoses including, but not limited to, seizures and muscle weakness. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed a nursing progress note dated 2/15/2025 indicating that the resident was noted with slurred speech, dilated pupils and leaning forward with his/her head down. The resident's vital signs were as follows; blood pressure 126/73 (normal range 100/65 to 120/80), heart rate 68 (normal range 60-100), respirations 16 (normal range 12-20), temperature 97.8 (normal range 97-99), pulse oximetry (blood oxygen level) was 94% (normal range 95-100%) on room air, and the blood sugar was 156 (normal level between 70-100). Upon further assessment, the resident had difficulty staying awake and was coughing with liquids. The on call provider was notified and orders were received to obtain blood work, a urine specimen, and to administer Narcan 0.4 milligram (mg) intranasally for a one time administration. Further review revealed the Narcan was administered, as ordered. Record review failed to reveal evidence that an SUD Assessment was completed upon admission, per the facility policy. Further record review failed to reveal evidence that the resident had an order for an opioid medication. During a surveyor interview on 3/3/2025 at 11:30 AM with Licensed Practical Nurse (LPN), Staff C, she was unable to provide evidence that an SUD Assessment was completed for the resident. Additionally, she acknowledged that the resident's clinical presentation on 2/15/2025, was not indicative of a narcotic overdose, per the facility policy. During a surveyor interview on 3/3/2025 at 11:46 AM with LPN, Staff D, she revealed that when she went to administer the resident his/her medications on 2/15/2025, the resident was lethargic but arousable. She further revealed that she contacted the on-call provider, reviewed the resident's medications and the provider ordered lab work, diagnostic testing and Narcan. Staff D revealed she also performed a sternal rub and that the resident would awaken but then become lethargic again. Staff D revealed she was not familiar with the Narcan policy and after reviewing the policy with the surveyor, Staff D acknowledged that the resident's pupils were not pinpoint, rather very dilated, s/he was arousable at times and his/her vital signs were normal. Additionally, Staff D revealed she did not call 911 per the facility policy. During a surveyor interview on 3/3/2025 at 11:43 AM with the Administrator, she was unable to provide evidence that the facility policy was followed related to a SUDs Assessment, the assessment of a resident to meet the criteria of an overdose, and to call 911 prior to the administration of Narcan. 2a. According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, .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 Resident ID #44 was admitted to the facility in December of 2020 with a diagnosis including, but not limited to, ocular hypertension (a condition where the pressure in the eye is higher than normal). Record review revealed a physician's order dated 11/11/2021 for Latanoprost Solution 0.005 % (a medication prescribed to reduction the fluid pressure inside the eye) eye drops, instill 1 drop in both eyes at bedtime. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview and simultaneous observation with the resident in his/her room on 2/27/2025 at 9:24 AM, s/he revealed that s/he has not been receiving his/her Latanoprost eye drops at bedtime. S/he further revealed that the eye drops are left at his/her bedside for him/her to administer, but they have not been available for approximately two to four weeks. Additionally, s/he revealed that s/he has been told by staff that they have been waiting for the pharmacy to deliver the eye drops. Surveyor observation of the resident's room failed to reveal evidence of the Latanoprost eye drops. Record review revealed a completed Self-Administer Screening document, dated 4/28/2023 for the Latanoprost eye drops. Further review of the document indicates the resident is completely safe to administer the medication and that the eye drops can be left at his/her bedside. Record review of the February 2025 Medication Administration Record (MAR) from 2/1/2025 through 2/27/2025 revealed the Latanoprost eye drops were signed off as administered. During a surveyor interview and simultaneous observation on 2/27/2025 at 9:50 AM with Registered Nurse, Staff E, she acknowledged that the Latanoprost eye drops were signed off as administered and according to the MAR documentation, the eye drops were last ordered from the pharmacy on 12/25/2024. During the interview with Staff E, she was unable to locate the Latanoprost eye drops. During a surveyor interview on 2/27/2025 at approximately 9:55 AM with Medication Aide, Staff F, he acknowledged that the Latanoprost eye drops were not in the medication cart and that they are kept at the resident's bedside for him/her to administer. During a subsequent interview on 2/27/2025 at approximately 10:00 AM with Staff E, she placed a call to the pharmacy in the presence of the surveyor, to inquire about the eye drops. Staff E was told by the pharmacist that the eye drops were last ordered on 12/25/2025 and that they were never re-ordered. During a surveyor interview on 2/27/2025 at 11:39 AM with the Director of Nursing Services (DNS), she revealed that she would have expected the nurse to call the pharmacy to ensure the delivery of the medication. Additionally, she could not provide evidence that the Latanoprost eye drops were administered, as ordered, from 2/1/2025 through 2/27/2025. 2b. Record review revealed Resident ID #78 was readmitted to the facility in December of 2024 with diagnoses including, but not limited to, diabetes mellitus and a right hallux (great toe) infection. Record review revealed the resident was evaluated by the podiatrist on 2/24/2025 and recommendations were made for a treatment to cleanse the wound with Betadine (an antiseptic solution used for skin disinfection) and to apply triple antibiotic ointment, twice daily for 10 days, then leave it open to air. Record review of a nursing progress note dated 2/24/2025 revealed the resident's provider was notified and in agreement with the podiatrist's treatment recommendations. Record review of the physician's orders failed to reveal evidence that the above podiatrist's recommendations were implemented. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 3/3/2025 at 8:51 AM with Registered Nurse, Staff G, she acknowledged that the podiatrist's recommendations had not been implemented. During a surveyor interview on 3/3/2025 at 9:02 AM with the DNS, she acknowledged that the podiatrist's recommendations were not implemented for the resident's wound, as ordered. 2c. Review of a facility policy titled, Clean Dressing Technique dated January of 2018 states in part, .It is the policy of this facility to prevent the spread of infection by utilizing proper dressing change techniques .Check the physician order for current, correct treatment .Open supplies onto the clean field .Remove gloves. Wash hands. (Hand sanitizer may be used) Apply clean gloves .using the no touch technique i.e., do not directly touch any item that will come in contact with the wound .Apply any medication ordered and dress wound. Remove gloves and wash hands . Record review revealed Resident ID #83 was originally admitted to the facility in December of 2023 with diagnoses including, but not limited to, chronic venous hypertension with an ulcer (a condition characterized by elevated venous pressure, which leads to vein dilation, skin changes, and wounds) and a Methicillan Resistant Staphylococcus Aureus (multidrug resistant bacteria). Record review of the physician's orders revealed a treatment order dated 2/13/2025 to cleanse the wound with Vashe Solution (wound cleanser to clean, irrigate, and remove infected or damaged tissue), apply A&D ointment around the wound, then apply Adaptic (a nonadherent petrolatum gauze that is applied in the base of the wound bed) followed by blue foam moistened with normal saline, cover with an absorbent pad, wrap with gauze roll, and then wrap with ACE bandages. During a surveyor observation of a wound dressing change on 2/27/2025 at 10:03 AM with LPN, Staff H, revealed she failed to perform hand hygiene between glove changes and used a gloved finger to apply the A & D ointment rather than an applicator. Additionally, she failed to cut the Adaptic gauze to the size of the wound bed and failed to apply the ace bandages, as ordered. During a surveyor interview on 2/27/2025 at 10:44 AM and at 11:26 AM with Staff H, she acknowledged that she failed to perform hand hygiene between glove changes, did not cut the Adaptic gauze, and used her gloved hand to apply the ointment as she left the applicator on the cart. Additionally, she acknowledged that she had forgotten to apply the resident's ace bandages. 2d. Record review revealed Resident ID #123 was admitted to the facility in December of 2022 with a diagnosis including, but not limited to, high cholesterol. Record review revealed the resident had blood work obtained for a lipid panel (various levels of fats in the blood including cholesterol and triglyceride levels). Record review of a provider progress note dated 2/7/2025 authored by the Nurse Practitioner (NP), Staff I, indicated the resident has slightly elevated cholesterol levels and she indicated in her plan to implement a low dose of Atorvastatin 20 mg, every night, at hour of sleep. Record review of the physician's orders failed to reveal evidence of an order for Atorvastatin. During a surveyor interview on 3/3/2025 at 11:21 AM with LPN, Staff J, he acknowledged that the resident does not have an order for Atorvastatin. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 3/3/2025 at 11:24 AM with NP, Staff I, she acknowledged that she ordered for the resident to receive Atorvastatin 20 mg, at hour of sleep. 3. According to Mosby's Fundamentals of Nursing Concepts, Process and Practice, 4th Edition, on page 809, .A Registered Nurse checks all transcribed orders against the original order for accuracy and thoroughness. Record review revealed Resident ID #123 was admitted to the facility in December of 2022 with a diagnosis including, but not limited to, conditions of the skin. Record review revealed a physician's order dated 2/18/2025 for Triamcinolone Acetonide cream (a topical cream prescribed to treat skin conditions) 0.025 %, apply to rashes topically, two times a day, for rashes. Further review of the order failed to reveal evidence of a location indicated for the cream to be applied. During a surveyor observation and simultaneous interview on 2/27/2025 at 10:57 AM with LPN, Staff B, she revealed that she was not certain where the Triamcinolone cream was to be applied. Staff B further revealed that the resident's previous cream order was for the top of the resident's feet and back of legs. During an observation of the resident's feet and their legs, no rash wash observed. Additionally, Staff B acknowledged that the Triamcinolone order did not indicate a location for where the cream is to be applied. During a surveyor interview on 2/27/2025 at 11:47 AM with the DNS, she revealed that she would have expected the Triamcinolone order to include a location for the treatment and she acknowledged that it did not. 4. According to Lippincott Nursing Procedures, 9th edition, states in part, .Anticipate monitoring for therapeutic levels of any antiseizure medications that the patient is taking . Record review revealed Resident ID #95 was initially admitted to the facility in August of 2020 with diagnoses including, but not limited to, major depressive disorder, psychotic disturbance, mood disturbance, and convulsions (involuntary, rhythmic muscle contractions that can be a symptom of seizures). Record review of the physician's orders revealed the resident has been receiving Valproic Acid (a medication prescribed to treat seizures and certain behavioral disorders), delayed release 250 mg, twice daily, since 4/21/2024. Record review failed to reveal evidence that a Valproic Acid level was obtained by the facility and monitored. During a surveyor interview on 2/28/2025 at 3:08 PM with LPN, Staff C, she was unable to provide evidence that a Valproic Acid level had been obtained. Record review of a nursing progress note dated 3/3/2025 at 10:05 AM, authored by Staff C, revealed that she had contacted the resident's provider relative to there not being a Valproic Acid level and that the provider ordered a Valproic Acid level to be obtained every 6 months with routine lab work, after it was brought to the facility's attention by the surveyor. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview with the facility's Pharmacy Consultant on 3/3/2025 at 9:10 AM, she revealed that she would expect a Valproic Acid level to be ordered by the provider, every 6 months. An attempt was made to conduct a telephone interview on 3/3/2025 at 9:44 AM by the surveyor with the resident's physician and NP. A message was left for both providers, however no return call was received. 46118 48928

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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. 46539 Based on 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 and the comprehensive care plan relative to 1 of 3 wounds observed, Resident ID #137. Findings are as follows: Record review revealed Resident ID #137 was readmitted to the facility in October of 2024 with diagnoses including, but not limited to, acquired absence of right leg below the knee and acquired absence of left leg above the knee. Review of a progress note dated 2/12/2025 revealed, the resident had an abrasion to his/her right knee. Review of a progress note dated 2/19/2025 revealed, the resident has a wound to his/her right knee. During a surveyor observation on 2/26/2025 at 10:00 AM, revealed a wound dressing to the resident's right knee wound with a date of 2/23/2025, 3 days prior to the wound observation. Record review failed to reveal a physician's order to care for the right knee wound. Record review failed to reveal evidence that at the time the wound was identified on 2/19/2025 that the wound documentation included the size of the wound, wound edges, the wound bed, shape, and the condition of surrounding tissue, per the regulation. Additional review failed to reveal evidence that the physician was notified of the wound or that an order was obtained to provide wound care. During a surveyor interview on 2/26/2025 at 10:03 AM, with Licensed Practical Nurse, Staff H, she revealed that she was unable to find physician notification, a physician's order, or characteristics of the wound. During a surveyor observation on 2/26/2025 at 10:04 AM, of the wound with Staff H, she removed the old dressing to reveal the right knee which was covered with blood. She then cleaned the area to reveal a U-shaped wound to the resident's right knee. Staff H acknowledged that the dressing she removed was dated 2/23/2025. During a surveyor interview on 2/26/2025 at 2:45 PM, with the Director of Nursing Services, she acknowledged that there was no documentation regarding Resident ID #137's wound to his/her right knee and would expect there to be documentation of the characteristics per the regulation and an order for wound care and the physician to be notified of a new wound.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 46539 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that residents with pressure ulcers receive the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 of 1 resident observed with a pressure ulcer, Resident ID #3. Findings are as follows: According to Infection Control Assessment and Response (ICAR) Tool for General Infection Prevention and Control (IPC) Across Settings .Wound Care Facilitator Guide from the Centers for Disease Control and Prevention last revised on 1/27/2023, states in part, .Maintain separation between clean and soiled equipment to prevent cross contamination .Any unused disposable supplies that enter the patient/resident's care area should remain dedicated to that patient/resident or be discarded. They should not be returned to the clean supply area. If supplies are dedicated to an individual patient/resident, they should be properly labeled and stored in a manner to prevent cross-contamination or use on another patient/resident (e.g., in a designated cabinet in the patient/resident's room) .Containers entering patient/resident care areas should be dedicated for single-patient /resident use or discarded after use . Review of a facility policy titled, Clean Dressing Technique dated January of 2018 states in part, .It is the policy of this facility to prevent the spread of infection by utilizing proper dressing change techniques .pour solutions into a clean container; prepare ointments, medication .using the no touch technique i.e., do not directly touch any item that will come in contact with the wound . Record review revealed that Resident ID #3 was readmitted to the facility in October of 2024, with a diagnosis including, but not limited to, type 2 diabetes mellitus. Review of a wound evaluation and management summary dated 2/18/2025, revealed that Resident ID #3 has a stage 3 pressure wound (Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue new connective tissue and microscopic blood vessels that form on the surfaces of a wound during the healing process) of the left lateral foot for greater than 138 days. It further revealed that the wound had light serous drainage (clear to yellow fluid that leaks out of a wound). Record review revealed a physician's order dated 2/13/2025 for the left lateral foot wound to cleanse the wound with wound cleanser, apply skin prep (skin protectant) to the surrounding wound, apply Silvadene (a cream used to treat or prevent serious infection on areas of skin) to the wound, and cover with island border gauze daily. (continued on next page)

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Trinity Health and Rehabilitation Center	4 St Joseph Street Woonsocket, RI 02895

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor observation on 2/26/2025 at 9:03 AM, with Registered Nurse, Staff K, of Resident ID #3's wound care revealed, Staff K brought in the wound care supplies including a multiuse (a product used for more than one resident) Silvadene jar into Resident ID #3's room. He then proceeded to cleanse the wound and apply the Silvadene cream to the left lateral foot by sticking his gloved finger into the multiuse jar and then applied the Silvadene to the wound bed with his gloved finger. He failed to follow the no touch method described in the facility policy. After completion of the wound care, Staff K returned the multiuse jar into the treatment cart. During a surveyor interview with Staff K immediately following the above-mentioned observation, he acknowledged that he brought a multiuse jar of Silvadene into Resident ID #3's room, utilized his gloved finger to apply the Silvadene on to the wound bed, and then returned the jar into the treatment cart. Additionally, he acknowledged that he did not follow the no touch method, per the facility policy. During a surveyor interview on 2/26/2025 at approximately 3:00 PM, with the Director of Nursing Services, she revealed that she would expect the staff not to bring multiuse supplies into a resident's room. Additionally, she revealed that she would expect an applicator to be used when applying a cream to the wound.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 50004 Based on surveyor observation, record review, resident and staff interview, it has been determined that the facility failed to provide appropriate treatment and services for 1 of 1 resident reviewed with a nephrostomy tube (PCN, a catheter that is inserted through your skin and into your kidney), Resident ID #64. Findings are as follows: Record review revealed Resident ID #64 was admitted to the facility in February of 2025 with a diagnosis including, but not limited to, obstructive and reflux uropathy (a condition in which the flow of urine is blocked). Record review of a hospital discharge document titled, Discharge Summary dated 2/6/2025 revealed an order to irrigate the PCN tube with 10 milliliters of normal saline daily and as needed. Record review failed to reveal evidence that the PCN tube was flushed from 2/7/2025 until 2/27/2025, for a total of 21 days. During a surveyor interview on 2/26/2025 at 10:29 AM with the resident, s/he indicated that his/her PCN tube was last flushed in the hospital prior to coming to the facility. During a surveyor interview on 2/27/2025 at 1:06 PM, with Registered Nurse, Staff G, she revealed that the resident did not have an order to flush his/her PCN tube. She further acknowledged that the order from the hospital was never transcribed. During a surveyor interview on 2/27/2025 at 1:34 PM with the Nurse Practitioner, Staff I, she indicated that the order was approved on admission and unaware it was not being completed, until brought to the facility's attention by the surveyor. During a surveyor interview with the Administrator on 2/27/2025 at 2:40 PM she revealed that she would have expected the PCN tube to be flushed daily and the hospital order to be transcribed on admission.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 50004 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide respiratory care consistent with professional standards of practice for 1 of 1 resident reviewed for suctioning, Resident ID #96. Findings are as follows: Record review revealed Resident ID #96 was admitted to the facility in January 2025 with diagnoses including, but not limited to, dysphagia (a condition resulting in difficulty swallowing food or liquid), aspiration pneumonia (infection of the lungs caused by inhaling saliva, food, liquid, vomit), and acute respiratory failure. Record review of a facility document titled, Policy for Suctioning a Patient states in part, .The purpose of this policy is to establish clear and comprehensive guidelines for performing suctioning procedures to maintain airway patency, prevent respiratory distress and ensure patient safety .infection control: Use sterile technique for invasive suctioning. Dispose of used catheters and gloves appropriately. Clean and disinfect suction equipment after each use . Record review of a physician's order dated 2/19/2025 revealed to suction as needed for increased secretions. Record review of the February 2025 Medication Administration Record revealed the above order was signed off as completed on 2/19/2025. Record review of a nursing progress note dated 2/19/2025 states in part, .Increased secretions noted, suctioned with good effect . Record review of a medication administration note dated 2/19/2025 states, suction as needed for increased secretions as needed: large amount of viscus[sic] sputum (thick, sticky sputum). During multiple surveyor observations from 2/24/2025 through 2/26/2025 revealed a suction canister and tubing with no date. The canister contained multi-colored secretions with floating sediment and tan colored fluid within the tubing. During a surveyor interview on 2/26/2025 at 10:01 AM following the above-mentioned observation with Registered Nurse, Staff G, she revealed that she was unsure what date/time the suction machine was last used or how long the secretions had been in the canister. Additionally, she was unsure of when to clean or change the equipment. Record review failed to reveal evidence of when to change, clean or replace the suction equipment. During a surveyor interview with the Director of Nursing Services on 2/26/2025 at 2:40 PM, she revealed that she would have expected the canister and the tubing to be dated and discarded after 24 hours.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 46241 Based on record review and staff interview, it has been determined that the facility failed to ensure that residents are free of any significant medication errors for 1 of 2 residents reviewed for warfarin (Coumadin, a medication prescribed to prevent blood clots), Resident ID #23. Findings are as follows: Review of a policy titled Guidelines for Anticoagulation Management states in part, .When ordering the anticoagulant, the physician is to indicate the indication for the therapy and the desired therapeutic range . Whenever an anticoagulation therapy is administered it is to be monitored by evaluating the effect on the PT/INR [prothrombin time test/international normalized ratio, a test used to evaluate the therapeutic ranges for warfarin] .Any changes in coumadin dosage will be made accordingly. An order must be received from the MD [Medical Doctor] for the lab work . Review of a document titled A Guide to Taking Warfarin created by the American Heart Association, states in part, .It's important to monitor the INR at least once a month and sometimes as often as twice weekly to make sure the level of warfarin remains effective. If the INR is too low, blood clots will not be prevented, but if the INR is too high, there is an increased risk of bleeding . Record review revealed the resident was readmitted to the facility in August of 2024 with diagnoses including, but not limited to, lupus anticoagulant syndrome (an autoimmune disease characterized by malfunctioning antibodies) and a personal history of pulmonary embolism (a blood clot that blocks and stops blood flow to an artery in the lung). Record review revealed a care plan focus area last revised 7/31/2024, the resident is on anticoagulant therapy with interventions that include, but not limited to; administer anticoagulant medications as ordered by the physician and to monitor for side effects and effectiveness routinely. Record review revealed the following physician orders: - 1/8/2025 for Warfarin, 3 milligram (mg) with instructions to administer one tablet, one time a day, and give 3 mg with 0.5 mg for a 3.5 mg total dose. - 1/8/2025 for Warfarin, 1 mg with instructions to administer half a tablet one time a day and give 3 mg with 0.5 mg for a 3.5 mg total dose. Review of document titled Lab Results Report dated 2/3/2025 revealed an INR value of 1.8 (therapeutic ranges for an oral anticoagulant is 2.0 - 3.0) indicating the resident had a low INR, increasing their risk for blood clot development. Review of a progress note dated 2/5/2025 revealed the 2/3/2025 lab results were reviewed with the Nurse Practitioner (NP) and a new order was received to increase warfarin to 4 mg daily and to repeat the INR in 1 week. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review failed to reveal evidence that the resident's warfarin was increased to 4 mg daily, as ordered. Further record review failed to reveal an INR was obtained one week later, as ordered by the provider. Additionally, record review failed to reveal evidence that an INR was obtained since 2/3/2025, 21 days after the order was received to recheck the INR. During a surveyor interview on 2/26/2025 at 8:44 AM, with NP, Staff N, she revealed that she would have expected the facility to redraw the residents INR labs in one week and increase the warfarin to 4 mg when it was ordered. During a surveyor interview on 2/26/2025 at 8:48 AM, with Licensed Practical Nurse, Staff J, he acknowledged that the resident was still receiving 3.5 mg of warfarin daily and acknowledged that the order to increase warfarin to 4 mg daily was not transcribed. Further, he acknowledged that the resident did not have another INR test completed one week after it was ordered by the NP on 2/5/2025. During a surveyor interview on 2/26/2025 at 8:55 AM with the Director of Nursing Services, she acknowledged that the resident was still receiving warfarin 3.5 mg daily and that the order was not increased, as ordered by the NP on 2/5/2025. Further, she acknowledged that the resident's INR was not redrawn after one week, as ordered, and revealed it has not been drawn since 2/3/2025. Review of document titled Lab Results Report dated 2/26/2025, obtained after this concern was brought to the facility's attention by the surveyor, revealed an INR value of 1.4, indicating the resident had a low INR further increasing the resident's risk for blood clot development. Review of the February 2025 Medication Administration Record revealed the resident received a one-time dose of 7.5 mg of warfarin on 2/26/2025, after the lab results were reviewed by the physician. Cross reference F 770

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. 37158 Based on surveyor observation and staff interview, it has been determined that the facility failed to store and label drugs and biological's in accordance with currently accepted professional principles for 3 of 8 medication carts observed on 3 of 4 units and 1 of 2 medication storage rooms observed. Findings are as follows: 1. During a surveyor observation on 2/26/2025 at 3:57 PM of the 3rd floor medication room, in the presence of Licensed Practical Nurse, Staff J the following was revealed: -One bottle of Lorazepam Intensol, opened without a date. Review of the manufacturer's instructions indicate to discard the Lorazepam 90 days after opening. During a surveyor interview with Staff J, he acknowledged that the Lorazepam Intensol was opened without a date and revealed medications should be dated when opened. 2. During a surveyor observation on 2/26/2025 at approximately 10:30 AM of a 2nd floor unit medication cart, in the presence of Certified Medication Technician (CMT), Staff F, the following was revealed: -One bottle of Active Critical Care Protein supplement, opened without a date. Review of the manufacturer instructions indicates the protein supplement expires 90 days after opening. -One Incuse inhaler 62.5 micrograms (mcg), opened without a date. Review of the manufacturer's instructions indicate to discard the inhaler 6 weeks after opening. -One Fluticasone propionate 500/50 mcg inhaler, opened without a date. Review of the manufacturer's instructions indicate to discard the inhaler 6 weeks after opening. During a surveyor interview immediately following the above observations with Staff F, he revealed that medications should be dated when opened. 3. During a surveyor observation on 2/26/2025 at approximately 11:00 AM of a ground level unit medication cart, in the presence of CMT, Staff O the following was revealed: -One Wixela 500/50 mcg inhaler, opened without a date. Review of the manufacturer's instructions indicate to discard the inhaler one month after opening. During a surveyor interview on 2/26/2025 immediately following the observation with Staff O, she acknowledged the inhaler was opened without a date and should have been dated when opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a surveyor observation on 2/26/2025 at 3:43 PM in the presence of Registered Nurse, Staff K, of the controlled substance locked box located in a 1st floor medication cart, the following was revealed: Record review of the narcotic book indicated Resident ID #151 has an order to receive Oxycodone 5 mg every 6 hours, as needed for pain. Record review of the resident's available Oxycodone revealed the narcotic count log indicated s/he had 27 tablets remaining. Review of the pharmacy blister pack, containing the Oxycodone medication, revealed the resident had 26 tablets remaining, indicating there was 1 tablet that was not accounted for. During a surveyor interview immediately following the observation with Staff K, he revealed that he had administered the resident his/her Oxycodone earlier at approximately 8:00 AM this morning and forgot to sign the medication out of the narcotic count log. When Staff K was asked to provide evidence of when he administered the Oxycodone in the Electronic Medication Administration Record (EMAR), he was unable to do so, stating he had forgotten to sign the medication off as administered in the EMAR. During a surveyor interview on 2/26/2025 at 4:38 PM with the Administrator, she revealed that when a controlled medication is administered, she would expect the 5 rights and checks to be followed, and that the medication is signed off as administered in both the EMAR and the narcotic book. During a surveyor interview on 2/27/2025 at approximately 11:30 AM with the Director of Nursing Services, she revealed that she would expect that the above medications listed to be dated when opened.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46241 46539 Based on record review and staff interview, it has been determined that the facility failed to obtain laboratory services to meet the needs of its residents for 1 of 2 reviewed for warfarin (Coumadin, a medication prescribed to prevent blood clots), Resident ID #23 and for 1 of 2 residents reviewed with an elevated white blood count (WBC), Resident ID #420. Findings are as follows: 1. Review of a policy titled Guidelines for Anticoagulation Management states in part, .Whenever an anticoagulation therapy is administered it is to be monitored by evaluating the effect on the PT/INR [prothrombin time test/international normalized ratio, a test used to evaluate the therapeutic ranges for warfarin] .Any changes in Coumadin dosage will be made accordingly. An order must be received from the MD [Medical Doctor] for the lab work . Review of a document titled A Guide to Taking Warfarin created by the American Heart Association, states in part, .It's important to monitor the INR at least once a month and sometimes as often as twice weekly to make sure the level of warfarin remains effective. If the INR is too low, blood clots will not be prevented, but if the INR is too high, there is an increased risk of bleeding . Record review revealed the resident was readmitted to the facility in August of 2024 with diagnoses including, but not limited to, lupus anticoagulant syndrome (an autoimmune disease characterized by malfunctioning antibodies) and a personal history of pulmonary embolism (a blood clot that blocks and stops blood flow to an artery in the lung). Record review revealed the resident is prescribed warfarin daily. Review of document titled Lab Results Report dated [DATE] revealed an INR value of 1.8 (therapeutic ranges for an oral anticoagulant is 2.0 - 3.0) indicating the resident had a low INR increasing his/her risk for blood clot development. Review of a progress note dated [DATE] revealed, Nurse Practitioner (NP), Staff N, gave an order to obtain an INR in 1 week. Record review failed to reveal evidence that an INR test was obtained one week later, as ordered by the provider. Further record review failed to reveal an INR was obtained since [DATE], 21 days after the order was received to recheck the INR. During a surveyor interview on [DATE] at 8:44 AM, with NP, Staff N, she revealed that she would have expected the facility to redraw the resident's INR labs in one week, as ordered. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on [DATE] at 8:48 AM, with Licensed Practical Nurse, Staff J, he acknowledged that an INR test was not obtained one week after it was ordered by the NP on [DATE] and acknowledged that an INR test had not been obtained since [DATE]. During a surveyor interview on [DATE] at 8:55 AM with the Director of Nursing Services (DNS), she acknowledged that the resident's INR was not redrawn after one week, as ordered by the NP, and that an INR had not been obtained since [DATE]. Review of document titled Lab Results Report dated [DATE], obtained after this concern was brought to the facility's attention by the surveyor, revealed an INR value of 1.4, indicating the resident had a low INR further increasing Resident ID #23's risk for blood clot development. 2. Record review of a community reported complaint submitted to the Rhode Island Department of Health on [DATE], alleges concerns regarding quality of care related to the completion of a medical work up. Review of an undated policy titled Notification of Clinicians states in part, .Purpose: This facility acknowledges that prompt follow up to abnormal results of lab tests, x-ray and other diagnostic testing is essential to the promote the highest physical well-being of our residents. It is the policy of this facility to ensure that prescribing practitioners (physician, physicians' assistants, nurse practitioner, or clinical nurse specialist) are notified of laboratory, radiology and other diagnostic test results that fall outside of clinical reference ranges in a timely manner/or as per physicians' orders. PROCEDURE: 1. The results of laboratory, radiology and other diagnostic tests will be reviewed by the unit nurse on the same day that they are received by the facility. 2. Any results of laboratory, radiology and other diagnostic tests that fall outside of the clinical reference range will require notification to the prescribing practitioner as per their specific orders or within the shift it was received. 3. When necessary if the results (outside of the clinical reference range) were not able to be reported to the prescriber on the shift they were received; they will be called/reported on the next shift . Record review revealed Resident ID #420 was readmitted to the facility in September of 2024 with diagnoses including, but not limited to, neutropenia (a condition characterized by low levels of white blood cells, which protect the body from infections) and sepsis (a condition that arises when the body's response to infection causes injury to its own tissues and organs). Review of a lab results report dated [DATE] revealed the resident's WBC's count was 16.8 (normal range is 4. 0 - 10.0 thousands per cubic milliliter (K/uL), elevated WBC could indicate an infection) indicating that Resident ID #420 could have an infection. Record review revealed a physician order dated [DATE] for a urinalysis with culture and sensitivity (U/A C&S) to be obtained via clean catch (a method of collecting urine for testing that aims to prevent contamination) or straight catheter (a flexible tube inserted into the bladder to drain urine) method, per the provider, due to the resident's elevated WBC. Review of the [DATE] Medication Administration Record revealed the UA C&S order was documented as 5 on [DATE], indicating it was not completed and to see progress notes. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes revealed an administration note dated [DATE] indicating the U/A C&S was unable to be obtained. Record review failed to reveal evidence that the U/A C&S ordered on [DATE] was obtained, or the provider was notified in a timely manner that the U/A C&S was unable to be obtained. Review of a document titled medications not received revealed Resident ID #420's UA C&S was documented as not obtained on [DATE]. Further review revealed the NP signed the document on [DATE], 16 days after the UA C&S was ordered. Review of a lab results report dated [DATE] revealed the resident's WBC was 15.1 K/uL. Record review failed to reveal evidence that the physician or NP were notified of the residents WBC on [DATE]. Review of a lab results report dated [DATE] revealed the resident's WBC was 17.5 K/uL. Record review revealed the NP was notified of the resident's high WBC on [DATE], two days after the value was identified, and not on the same day that they are received or the next shift, per the facility policy. Further record review revealed that on [DATE] the resident was sent to the hospital. Review of hospital documentation dated [DATE] revealed that the resident arrived at the hospital after an acute mental status change and was hypotensive (low blood pressure less than 90) in the 80's. S/he was given one liter of normal saline. Additionally, the document revealed that the history from the patient was limited due to his/her altered mentation (mental status), lethargy and confusion. Furthermore, the hospital documentation revealed that on [DATE] the resident had an elevated WBC of 18.9. The resident was eventually transitioned to hospice service and expired while at the hospital. During a surveyor interview on [DATE] at 8:59 AM with Licensed Practical Nurse, Staff P, she revealed that she was the nurse on duty on [DATE] and reported the laboratory results to the provider. She revealed that the resident was more confused with increased weakness and was becoming more incontinent of urine. She revealed that she reported the laboratory results from [DATE] on [DATE] and the facility was going to obtain a complete workup including an additional U/A C&S. Additionally, she she was unable to provide evidence that the provider was notified of the laboratory results from [DATE] or that the U/A C&S was obtained as ordered on [DATE] or that the provider was notified of the inability to obtain the urine specimen. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on [DATE] at 9:40 AM with NP, Staff I, she revealed that when she is notified of abnormal laboratory results, she completes a workup, and indicated that if she had been notified, she would have done something in this scenario. Additionally, she revealed that she saw the resident on [DATE] but when she reviewed her documentation, she was unable to find evidence that the facility notified her of the increase in WBC on [DATE] or the increase in the WBC on [DATE] until [DATE]. Furthermore, she revealed that when she was reviewing her documentation that she was unable to provide evidence that she was notified that the U/A C&S was not obtained. Furthermore, she revealed she would expect to be notified if a resident had an elevated WBC or if there was an inability to obtain a U/A C&S. During a surveyor interview on [DATE] at 10:15 AM, with the Administrator and the DNS, they were unable to provide evidence of documentation for the missing labs. During a subsequent surveyor interview on [DATE] at 11:26 AM with the Administrator, she revealed that she would expect the staff to continue to attempt to obtain a U/A C&S if a urine is ordered. Additionally, she was unable to provide evidence Resident ID #420's laboratory results were reported in a timely manner, per the facility policy or obtained, per the regulation and physician orders. Cross reference F 760

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48928 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed ensure the director of food and nutrition services met the minimum qualifications of a Certified Food Safety Manager. Findings are as follows: Record review of the Rhode Island Food Code, 2018 Edition, Section ,d+[DATE].12 Certified Food Protection Manager states in part .at least one employee that has supervisory and management responsibility and the authority to direct and control food preparation and service shall be a certified food protection manager . During the initial tour of the main kitchen on [DATE] at 8:50 AM, surveyor observations failed to reveal evidence of a certification of a Food Safety Manager for the Food Service Director (FSD). Subsequently the FSD indicated that he had obtained the required education and certification and would present it at a later date. During a surveyor interview on [DATE] at approximately 9:30 AM, the FSD presented a Certificate of Completion for a Food Handler Training Course. The surveyor informed the FSD that the document provided does not meet the requirement of a Certified Food Safety Manager as required per regulations. Additionally, the Food Handlers Certificate provided had expired on [DATE]. During a surveyor interview on [DATE] at 2:37 PM with the FSD revealed that he was unaware he did not have the required Certified Food Safety Manager certification, until brought to his attention by the surveyor. During a surveyor interview on [DATE] at 1:42 PM with the Administrator, she presented a Certificate of Completion for a Food Handler Training Course. She indicated that she was unaware of the expiration date of [DATE], and that the certification was for a Food Handler, not a Food Safety Manager, as required, until brought to her attention by the surveyor. She revealed that she was unaware the FSD did not have the required certifications upon hire in November of 2024.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46539 48928 Based on surveyor observation, record review, resident and staff interview, it has been determined that the facility failed to provide food that is palatable, attractive, and at an appetizing temperature. Findings are as follows: Record review of a community reported complaint submitted to the Rhode Island Department of Health on 2/25/2025 alleges concerns regarding hot food items that are being served cold and at an unappetizing temperature. Record review of the Rhode Island Food Code 2018 edition, Section 3-501.16 Time/Temperature Control for Safety, Hot and Cold Holding states, .(A) Except during preparation, cooking or cooling .time/temperature control for safety food shall be maintained: (1) At 57 degrees Celsius (135 degrees Fahrenheit, F) or above . 1. Record review revealed Resident ID #10 was readmitted to the facility in June of 2021 with a diagnosis including, but not limited to, moderate protein-calorie malnutrition. Review of a Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating moderately impaired cognition. During a surveyor interview on 2/27/2025 at 3:07 PM with Resident ID #10, s/he revealed that hot food items are cold, and that s/he would like his/her hot foods to be served hot. 2. Record review revealed Resident ID #15 was readmitted to the facility in April of 2024, with a diagnosis including, but not limited to, type 2 diabetes. Review of an MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, indicating intact cognition. During a surveyor interview on 2/24/2025 at 1:35 PM with Resident ID #15, s/he revealed that the food is not cooked well. S/he revealed that the meals are cold and not fully cooked. 3. Record review revealed Resident ID #16 was readmitted to the facility in February of 2025 with a diagnosis including, but not limited to, anxiety disorder. Review of an MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, indicating intact cognition. During a surveyor interview on 2/26/2025 at 2:51 PM with Resident ID #16, s/he revealed that hot food items are served cold all the time and that the food does not taste good. S/he further revealed that s/he would expect his/her hot foods to be served hot. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the resident council meeting on 2/25/2025 at 1:04 PM it was identified by multiple residents in attendance that the food is always cold and that they would prefer their hot foods to be hot. During a surveyor observation on 2/26/2025 at 11:25 AM of the lunch meal plating process, revealed 10 serving trays were set up on the food service line, each containing a portion of macaroni and cheese alongside zucchini. At the time of the observation, the plated food was uncovered and exposed. The trays were observed to be stationary for greater than 90 seconds while additional items were added to each tray before slowly continuing down the assembly line for the plate to be covered and then placed into carts that transport the prepared meal trays to residents across various units. During a surveyor interview 2/26/2025 at 11:36 AM with the Food Service Director (FSD), he indicated that this procedure was the standard practice used for plating all meals. The surveyor requested the FSD to take a sample of temperatures of the plated meals on the line, which revealed the following: -A plated sliced ham steak was 128 (Fahrenheit) -A plated portion of macaroni and cheese was 125 Immediately following the above observation, the surveyor requested the FSD to obtain additional holding temperatures of plated meals that were being placed inside of a food cart, that were going to be delivered to one of the units for lunch service. A tray with macaroni and cheese had a temperature of 110 F, another tray of macaroni and cheese had a temperature of 102 F and a tray of sliced ham steak had a temperature of 115 F. The FSD indicated that he was unaware of that the safe holding temperature was 135 F or greater for hot food, prior to being informed by the surveyor. During a surveyor interview on 2/26/2025 at 11:46 AM with the FSD following the above observations, he acknowledged that temperatures obtained were below the safe holding temperatures of 135 F. Cross Reference F 812.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50004 48928 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that the Director of Food and Nutrition Services met the minimum qualifications of a Certified Food Safety Manager for 1 of 1 Food Service Director (FSD) reviewed. Additionally, the facility failed to ensure that food is stored and distributed, in accordance with professional standards for food safety relative to the main kitchen and 4 of 4 kitchenettes. Findings are as follows: 1. Record review of the Rhode Island Food Code, 2018 Edition, Section 2-102.12 Certified Food Protection Manager states in part .at least one employee that has supervisory and management responsibility and the authority to direct and control food preparation and service shall be a certified food protection manager . During the initial tour of the main kitchen on 2/24/2025 at 8:50 AM, surveyor observations failed to reveal evidence of a certification of a Food Safety Manager for the FSD. Subsequently the FSD indicated that he had obtained the required education and certification and would present it at a later date. During a surveyor interview with the FSD on 2/25/2025 at approximately 9:30 AM, he presented a Certificate of Completion for a Food Handler Training Course with an expiration date of 3/8/2024. The surveyor informed the FSD that the document provided does not meet the requirement of a Certified Food Safety Manager, per regulation. During a surveyor interview on 2/25/2025 at 2:37 PM with the FSD, he revealed that he was unaware that he did not have the required Food Safety Manager certification. During a surveyor interview on 2/26/2025 at 8:32 AM with the Dietitian, she revealed that she is at the facility 3 days per week on average. She indicated that she does not provide oversight of meal service including, preparing, cooking, and serving food to the residents. Record review of the facility time sheets for the dietary department for 1/1/2025 through 1/31/2025, and 2/1/2025 through 2/22/2025, revealed the following: - January time sheets failed to reveal evidence that a Certified Food Safety Manager was present during all three meal services for 20 out of 31 calendar days - February time sheets failed to reveal evidence that a Certified Food Safety Manager was present during all three meal services for 14 out of 22 calendar days (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a surveyor interview on 2/26/2025 at approximately 9:30 AM with the Administrator, she was unable to provide evidence that a Certified Food Safety professional was in the kitchen during all three meal services for the months of January and February 1, 2025, through February 22, 2025. During a surveyor interview on 2/26/2025 at 1:42 PM with the Administrator, she revealed that she was unaware that the FSD did not have the required certifications upon hire in November of 2024. 2. Record review of the Rhode Island Food Code 2018 edition, Section 3-501.16 Time/Temperature Control for Safety, Hot and Cold Holding states in part, .(A) Except during preparation, cooking or cooling time/temperature control for safety food shall be maintained: (1) At 57 degrees Celsius (135 degrees Fahrenheit) or above . During a surveyor observation on 2/26/2025 at 11:25 AM of the lunch meal plating process, revealed 10 serving trays were set up on the food service line, each containing a portion of macaroni and cheese alongside zucchini. At the time of the observation, the plated food was uncovered and exposed. The trays were observed to be stationary for greater than 90 seconds while additional items were added to each tray before slowly continuing down the assembly line for the plate to be covered and then placed into carts that transport the prepared meal trays to residents across various units. During a surveyor interview and observation on 2/26/2025 with the FSD at 11:36 AM, he indicated that this procedure was the standard practice used for plating all meals. The surveyor requested the FSD to take a sample of temperatures of the plated meals on the line, which revealed the following: -A plated sliced ham steak was 128 Fahrenheit (F) -A plated portion of macaroni and cheese was 125 F Immediately following the above observation, the surveyor requested the FSD to obtain additional holding temperatures of the plated meals that were observed plated on the service line for extended time prior to being placed inside of a food cart, that was going to be delivered to one of the units for lunch service revealed the following: -Two trays containing plated portions of macaroni and cheese had temperatures of 110 F and 102 F -A tray containing a plated portion of sliced ham steak meal had a temperature of 115 F The FSD indicated that he was unaware that food holding temperatures below 135 F were potentially hazardous until informed by the surveyor. Once he was informed, he acknowledged the low holding temperatures and proceeded to push the affected cart off to the side and he then stepped away from the service area. During a surveyor observation and interview on 2/26/2025 at 11:44 AM revealed Dietary Aide, Staff Z was placing the affected cart onto the elevator and was stopped by a surveyor. Staff Z revealed to the surveyor that he was delivering the cart to the 2nd floor for lunch service. He indicated that he had not been informed by the FSD of the unsafe holding temperatures of the plated meals in the affected cart. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a surveyor interview on 2/26/2025 at 11:46 AM with the FSD, he acknowledged that the temperatures obtained for meals in the cart were below the safe holding temperature of 135 F for hot foods and he directed the dietary staff and cooks to prepare an alternate meal for the 2nd floor lunch service. 3. Record review of Rhode Island Food Code, 2018 Edition, Section 3-501.17 states in part, n .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 . Review of the facility's policy titled, Use and Storage of Food Brought in by Visitors, states in part, .the dietary staff members assigned to routine rounds to stock/clean unit refrigerators/nutrition pantry will monitor status of food and discard perishable items that appear unsafe for consumption or older than 3 days . During the initial tour of the kitchen and 3 of 4 kitchenettes in the presence of the FSD, on 2/24/2025 at 8:20 AM, the following was observed: Main kitchen: -1 unlabeled and undated large blue bag, approximately 1/3 full of frozen croissants Ground Floor kitchenette: -2 full 64-ounce (oz) pitchers of orange juice labeled with a discard date of 2/21/2025 -2 full 64 oz pitchers of cranberry juice without a label indicating a discard date -1 half full 64 oz pitcher of orange juice without a label indicating a discard date 1st floor kitchenette: -one banana black in color in the refrigerator drawer -5 covered soup style bowls containing apple sauce, 3 labeled with discard dates of 2/19/2025 and 2 labeled with discard dates of 2/21/2025 -2 full 64 oz pitchers of apple juice with labels indicating a discard date of 2/21/2025 -1 half gallon of coffee ice cream approximately 1/4 full of substantial freezer burn without a label or indicating a discard date -1 covered soup style bowl containing diced pineapple without a label or indicating a discard date -A foil pack containing 4 slices of bread without a label or indicating a discard date -1 large Styrofoam to go container containing fried clams and French fries without a label or indicating a discard date (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-1 22 oz personal glass container of soup without a label or indicating a discard date -1 22 oz personal glass container of pasta without a label or indicating a discard date During a surveyor interview on 2/24/2025 at 8:50 AM with Certified Medication Technician, Staff R, following the above observations of the kitchenette, she acknowledged the food items should have been labeled, dated, or thrown away as indicated per facility policy. During a surveyor observation of the 3rd floor kitchenette on 2/25/2025 at 8:39 AM, in the presence of the FSD, the following was observed: -An unlabeled package containing 4 frozen waffles without a discard date -An 8 oz to go coffee of cup in the freezer -1 unlabeled covered soup style bowl of apple sauce with a discard date of 2/21/2025 During a surveyor interview on 2/25/2025 at 9:52 AM with the FSD, he acknowledged the above observations, and he indicated that he was unaware of the facility's policy Use and Storage of Food Brought in by Visitors. 4. Record review of the Rhode Island Food Code, 2018 Edition, section 4-601.1 1 states in part, .(A) equipment food contact surfaces .shall be clean to sight .(B) The FOOD CONTACT SURFACES of cooking EQUIPMENT .shall be kept free of encrusted grease deposits and other soil accumulations. (C) NON-FOOD CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris . During the initial tour of the main kitchen and 1st floor kitchenette on 2/24/2025 at 8:20 AM, the following was observed: -The microwave had an accumulation of a black matter splattered on the inside of the glass door, above the cooking area, and on the glass turn plate -The hoses connecting the bag-in-box juice dispensing system that is used for residents to dispense apple juice, cranberry juice, orange juice, a diet beverage with lemon flavor, and strawberry kiwi beverages were observed to have an accumulation of a dried, sticky substance on the connection pieces, hoses, and on the shelf where the boxes were resting -2 unlabeled large storage bins approximately 27 gallons in size, both more than half full containing a white powdered substance, visibly dirty with an accumulation of residue on the outside of the bins -The microwave on first floor kitchenette was observed with an accumulation of light brown matter on the inside of the glass door, above the cooking areas and on the glass turn plate (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a subsequent surveyor interview with the FSD following the above observations, he acknowledged the observations and indicated that the dietary staff were responsible for the cleanliness of the kitchen and kitchenettes. However, he was unable to provide evidence that routine cleaning and maintenance was performed. Cross Reference 804

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 37158 46118 46241 46539 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections, relative to contact precautions (utilized when a resident is known or suspected to be infected with a Multidrug Resistant Organism [MDRO] that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces in the resident's room), for 3 of 3 residents reviewed on contact precautions, Resident ID #s 25, 38, and 83; for 3 of 5 residents reviewed for enhanced barrier precautions (EBP- refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) Resident ID #s 3, 123 and 161; and for the handling of soiled linen in the laundry room. Findings are as follows: 1. Review of a facility policy titled, Isolation states in part, .Contact precautions require the use of appropriate PPE [Personal Protective Equipment], including a gown and gloves upon entering the contact precaution room . Record review revealed Resident ID #83 was readmitted to the facility in December of 2024, with a diagnosis including, but not limited to, cellulitis (a skin infection) of the right lower limb. Record review revealed that Resident ID #83 tested positive for Methicillin-resistant Staphylococcus Aureus, (MRSA, an MDRO) in his/her leg wound on 3/4/2024. Record review revealed that the resident's leg wound tested positive again in November of 2024 for MRSA. Surveyor observations on 2/24/2025, revealed signage posted on the resident's door indicating that s/he was on contact precautions and indicated that staff/visitors are to wear a gown and gloves prior to entering the room. During a surveyor observation on 2/24/2025 at 11:19 AM, Nursing Assistant (NA), Staff T, entered Resident ID #83's room without wearing a gown or gloves. During a surveyor interview with Staff T, immediately following this observation, she acknowledged the sign posted on the resident's door and acknowledged that she failed to wear a gown and gloves prior to entering the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 2/26/2025 at 8:31 AM with Licensed Practical Nurse, Staff H, she revealed that Resident ID #83 was on contact precautions for MRSA and that a gown and gloves are required prior to entering the room. During a surveyor interview on 2/26/2025 at 12:49 PM, with the Infection Preventionist, she revealed that she would expect all staff to follow the signage posted outside all of the residents' rooms. 2. Review of a facility policy titled, Policy for Discontinuance of Isolation Precautions states in part, .If a resident has been placed on isolation precautions for the following MDRO (Multi-Drug Resistant Organism) infections (MRSA .ESBL [Extended-spectrum beta-lactamases]) he/she may be downgraded to standard precautions if there is a negative screening confirmed for all above infections .The screen should be obtained 48 hours after antibiotic treatment . 2a. Record review revealed Resident ID #25 was readmitted to the facility in June of 2024, with a diagnosis including, but not limited to, urinary tract infection. Record review revealed that Resident ID #25 tested positive for ESBL in November of 2024. S/he was placed on contact precautions and was treated with antibiotic therapy. Surveyor observations on 2/24, 2/25, 2/26, 2/27, and 2/28/2025, failed to reveal signage posted outside of Resident ID #25's room indicating that s/he was on contact precautions. Record review failed to reveal evidence that Resident ID #25 had a negative screening for MRSA 48 hours after the completion of antibiotic therapy to remove the resident from precautions, per the facility's policy. During a surveyor interview on 2/28/2025 at 1:22 PM, with the Infection Preventionist, she was unable to provide evidence that a negative screening 48 hours after antibiotic therapy completion was performed indicating to remove the resident from precautions. Additionally, she acknowledged that per the facility policy, Resident ID #25 required a negative screening prior to removal of precautions. Furthermore, she acknowledged that Resident ID #25 was not on contact precautions, per the facility policy. 2b. Record review revealed Resident ID #38 was readmitted to the facility in June of 2024, with diagnoses including, but not limited to, chronic hepatitis and local infection of the skin and subcutaneous tissue. Record review revealed Resident ID #38 has an active wound to his/her right third finger and was being followed by a wound physician. Further record review revealed the resident tested positive for MRSA in his/her finger wound on 1/14/2025 and was treated with antibiotic therapy. Surveyor observations on 2/24/2025 failed to reveal signage posted outside of Resident ID #38's room indicating that s/he was on contact precautions. Record review failed to reveal evidence that Resident ID #38 had a negative screening 48 hours after the completion of antibiotic therapy to remove the resident from precautions, per the facility's policy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 2/26/2025 at 12:37 PM and 2/28/2025 at 1:14 PM, with the Infection Preventionist, she was unable to provide evidence that a negative screening 48 hours after antibiotic therapy completion was performed indicating to remove the resident from precautions. Additionally, she acknowledged that per the facility policy, Resident ID #38 required a negative screening for removal of precautions. Furthermore, she acknowledged that Resident ID #38 was not on contact precautions, per the facility policy. During a surveyor interview on 2/26/2025 at approximately 3:00 PM, with the DNS, she was unable to provide evidence that negative screening's for Resident ID #s 38 and 25 after completion of their antibiotics were completed to remove the residents from contact precautions. 3. Review of the Center for Disease Control and Prevention (CDC) document titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDROs) last reviewed 8/1/2023, 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 wounds . Review of a facility policy titled, Isolation states in part, .Enhanced Barrier Precautions [EBP]-This level of precaution expands the use of PPE beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high contact resident care activities that provide opportunities for .residents with chronic wounds or indwelling medical devices regardless of their MDRO colonization status will be on Enhanced Barrier Precautions for the duration of their stay or until the resolution of the wound or discontinuation of the indwelling medical device. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing . bathing/showering .providing hygiene .wound care . 3a. Record review revealed Resident ID #3 was readmitted to the facility in October of 2024, with a diagnosis including, but not limited to, type 2 diabetes mellitus. Review of a wound evaluation and management summary dated 2/18/2025 revealed, Resident ID #3 has a stage 3 pressure wound (Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue (new connective tissue and microscopic blood vessels that form on the surfaces of a wound during the healing process) of the left lateral foot for greater than 138 days. It further revealed that the wound had light serous drainage (a clear to yellow fluid that leaks out of a wound). Record review failed to reveal evidence that Resident ID #3 was placed on EBP related to a chronic wound to his/her lateral foot. During a surveyor observation on 2/26/2025 at 9:03 AM with Registered Nurse, Staff K, wound care was performed to Resident ID #3's left lateral foot. Staff K, did not wear a gown to perform wound care. During a surveyor interview immediately following the wound care, Staff K acknowledged that he did not wear a gown during wound care, although it was a stage 3 pressure wound. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415079	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Health and Rehabilitation Center	4 St Joseph Street Woonsocket, RI 02895

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 2/26/2025 at 12:39 PM, with the Infection Preventionist, she revealed that a chronic wound is defined as a wound that is greater than 30 days in duration. Additionally, she acknowledged that Resident ID #3 has had a wound for greater than 138 days and should be placed on EBP. 3b. Record review revealed Resident ID #123 was readmitted to the facility in February of 2025, with diagnoses including, but not limited to, type 2 diabetes mellitus and other specified disorders of the skin and subcutaneous tissue. Record review revealed a care plan last revised on 2/21/2025 revealed, Resident ID #123 is on EBP related to a wound with interventions that include, but is not limited to, gloves and gown to be worn prior to high-contact care activities. During a surveyor observation on 2/24/2025 at 2:26 PM revealed signage posted outside Resident ID #123's room for EBP. During a surveyor observation on 2/24/2025 at 2:27 PM revealed NA, Staff U, providing care to Resident ID #123 without a gown on. During a surveyor interview on 2/24/2025 at 2:41 PM with Staff U, she acknowledged that she provided care to Resident ID #123 without wearing a gown. Additionally, Staff U, acknowledged the signage outside of Resident ID #123's room and that she should have worn a gown during care. During a surveyor interview on 2/26/2025 at 12:41 PM, with the Infection Preventionist, she revealed that she would expect staff to follow the signage posted outside of Resident ID #123's room. 3c. Record review revealed Resident ID #161 was admitted to the facility in October of 2024, with a diagnosis including, but not limited to, dementia. Record review revealed the resident has a non-pressure wound to his/her left first toe for greater than 66 days. Additionally, it revealed that the wound had light serous drainage with the wound progress not at goal. Surveyor observations on 2/24, 2/25, 2/26, 2/27, and 2/28/2025 failed to reveal signage posted outside of Resident ID #161's room indicating that s/he was on EBP related to a chronic wound to his/her left toe. During a surveyor interview on 2/26/2025 at 12:39 PM and 2/28/2025 at 1:18 PM, with the Infection Preventionist, she revealed that a chronic wound is defined as a wound that is greater than 30 days in duration. Additionally, she acknowledged that the wound has been active for greater than 66 days. Furthermore, she was unable to provide evidence that the resident was placed on EBP for a chronic wound. During a surveyor interview on 2/26/2025 at approximately 3:00 PM, with the DNS, she was unable to provide evidence that EBP was followed per the facility policy and CDC. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of a facility policy titled Laundry Guidelines dated 10/18 states in part, POLICY: It is the policy of this facility to handle, store, process, and transport linen so as to prevent the spread of infection .Laundry Handling .All laundry will be handled as if it is potentially infectious and/or capable of transmitting infectious disease .Laundry workers will wear appropriate personal protective equipment when handling contaminated laundry . During a surveyor observation and interview on 2/28/2025 at 1:41 PM with Laundry Aid, Staff V, she was observed folding clean laundry. During the laundry room tour she revealed that she works on both the clean and dirty side. She revealed that she loaded the soiled linen that was currently running. She revealed that she only wears gloves when sorting and loading the washer with soiled laundry and that she does not wear a gown. Additionally, she revealed that when the laundry is bagged in blue bags that means that a resident is on precautions. During a surveyor observation and interview on 3/3/2025 at 8:56 AM revealed Laundry Aid, Staff W, sorting soiled laundry and wearing only gloves. She then dumped out a blue bag of soiled linen. When asked by the surveyor what the blue bag meant, she revealed that the blue bags were just heavily soiled linen. Furthermore, she revealed that there are gowns available to wear but that she does not wear them. During a surveyor interview on 3/3/2025 at 8:59 AM with Licensed Practical Nurse, Staff P, she revealed that the blue laundry bags are used for the rooms on precautions. During a surveyor interview with the Administrator on 2/28/2025 at 1:45 PM and 3/3/2025 at 11:26 AM and 2:30 PM, she revealed that blue bags are utilized for precautions rooms. Additionally, she revealed that gowns are not optional when sorting laundry and should be worn when sorting and loading the washing machine. Furthermore, she was unable to provide evidence that the laundry was handled, stored, processed, and transported to prevent the spread of infections, per the facility's policy.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 46241 Based on record review and staff interview, it has been determined that the facility failed to implement and maintain an effective training program for all newly hired employees, consistent with their expected roles, relative to orientation education, as outlined in the facility assessment, for 4 of 5 newly hired employees, Staff J, X, Y, and the Food Service Director (FSD). Findings are as follows: Review of the Facility Assessment, dated 7/18/2024, states in part, .Training topics upon hire and annually for all staff: - Abuse, neglect, and mandatory reporting - Activities that constitute abuse, neglect, and misappropriation of resident property, Procedures for reporting incidents, of abuse, neglect, or the misappropriation of resident property - Corporate compliance - program overview; what to report and how to report noncompliance; standard of care/ensuring quality - Cultural competency - Customer service - Dementia care - person - centered care for the cognitively impaired .eight hours within 120 days of hire for all direct caregivers .two hours upon hire and annually for non-direct caregivers . - Disaster planning, procedures, codes . - Emergency preparedness - lock out/tag out, fire safety - Heimlich maneuver (all staff upon hire .) encouraged - HIPAA - overview; how to maintain; resident rights; mandatory reporting - Infection control - standard, contact and droplet precautions; personal protective equipment; hand hygiene; post-exposure to body fluids; tuberculosis; pandemic flu plan - Residents' rights and (prevention of) fear of retaliation - Workplace safety, body mechanics - overview and reporting - Workplace violence and harassment; sexual harassment - Covid-19 . (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed the FSD was hired on 11/5/2024. Review of his training records failed to reveal evidence that he received education or training upon hire relative to abuse, neglect, and mandatory reporting, corporate compliance, cultural competency, customer service, dementia care, disaster planning, emergency preparedness, Heimlich maneuver, HIPPA, infection control, residents' rights, workplace safety, or Covid-19. Record review revealed Dietary Aide, Staff X, was hired on 12/22/2024. Review of her training records failed to reveal evidence that she received education or training upon hire relative to abuse, neglect, and mandatory reporting, corporate compliance, cultural competency, customer service, dementia care, disaster planning, emergency preparedness, Heimlich maneuver, HIPPA, infection control, residents' rights, workplace safety, or Covid-19. Record review revealed Licensed Practical Nurse, Staff J, was hired on 1/10/2025. Review of his training records failed to reveal evidence that he received education or training upon hire relative to abuse, neglect, mandatory reporting, corporate compliance, cultural competency, customer service, dementia care, disaster planning, emergency preparedness, Heimlich maneuver, HIPPA, infection control, residents' rights, workplace safety, or Covid-19. Record review revealed Dietary Aide, Staff Y, was hired on 1/31/2025. Review of her training records failed to reveal evidence that she received education or training upon hire relative to abuse, neglect, mandatory reporting, corporate compliance, cultural competency, customer service, dementia care, disaster planning, emergency preparedness, Heimlich maneuver, HIPPA, infection control, residents' rights, workplace safety, or Covid-19. During surveyor interviews with the Administrator on 2/26/2025 at 12:41 PM and 2:44 PM, 2/27/2025 at 11:05 AM, 2/28/2025 at 1:02 PM and 3/3/2025 at 1:01 PM, she revealed that when an employee is hired, they meet with Human Resources to complete all necessary forms and indicated that the only education they receive that day is on workplace violence, harassment and sexual harassment. She revealed that all staff are required to attend an orientation where they will receive the remainder of the mandatory education, as outlined in the Facility Assessment. Further, she acknowledged that Staff J, X, Y, and the FSD did not attend an orientation after they were hired. Additionally, she was unable to provide evidence that the above-mentioned in-services were completed for Staff J, X, Y, and the FSD, upon hire, as per the Facility Assessment.