

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415080	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Bayberry Commons		STREET ADDRESS, CITY, STATE, ZIP CODE 181 Davis Drive Pascoag, RI 02859	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Few	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46118</p> <p>Based on record review and staff interview, it has been determined that the facility failed to immediately consult with the resident's physician and notify them when there is a significant change in the resident's condition, for 1 of 1 resident reviewed who experienced a change in condition, Resident ID #2.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled Medication Administration Safety Program (MASP)- Physician Notification states in part, .When a regularly scheduled dose of medication is not administered due to resident refusal, unavailability, resident condition or absence from the facility, the physician should be notified .</p> <p>On 2/19/2025 at approximately 10:00 AM the surveyor requested the facility's policy on a change in condition for a resident from the Director of Nursing Services (DNS). When the DNS returned to provide the surveyor with all of the requested policies he indicated that the facility did not have a policy specific to a change in condition.</p> <p>Review a community reported complaint submitted to the Rhode Island Department of Health on 2/5/2025, alleged that Resident ID #2 was transported to the hospital following an unwitnessed fall at the facility on 2/4/2025. The complaint further alleged that the resident was .barely able to open [his/her] eyes . on 2/4/2025, prior to the fall.</p> <p>Record review revealed the resident was admitted to the facility in November of 2024 with diagnoses including, but not limited to, heart disease, acute pulmonary edema (an abnormal buildup of fluid in the lungs), and reduced mobility.</p> <p>Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status score of 15 out of 15, indicating the resident's cognition was intact. Further review of the MDS revealed that the resident required moderate assistance of one staff member for transfers and ambulation.</p> <p>Record review revealed the following progress notes:</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-1/30/2025- 2:30 PM- resident alert and oriented to self, is rousable, refused medication, refused meals.</p> <p>-1/31/2025- 2:26 AM- 3PM- 7AM resident soundly sleeping at beginning of shift, unable to arouse with verbal stimulation, needed to use moderate tactile stimulation and still barely awoken, before supper s/he was noted to be attempting to get out of bed by him/herself.</p> <p>-1/31/2025- 9:52 PM- max assist times two staff with care this evening, refused dinner, poor fluid intake this evening.</p> <p>-2/1/2025- 3:31 PM- resident noted to be intermittently sleeping in chair though easily roused.</p> <p>-2/2/2025- 12:05 AM- per family members all conversation was non-sensical, having notable difficulty with ambulation, at times requiring the assistance of two staff, appetite continues to be poor.</p> <p>-2/2/2025- 11:41 PM- report from 7-3 shift stated that resident had not voided (urinated) that shift, physician gave orders to straight cath (procedure of inserting a tube into the bladder to allow the urine to empty) if no void in 8 hours, resident voided twice this shift, poor appetite and fluid intake.</p> <p>-2/3/2025- 8:02 AM- at approximately 2 AM the resident was noted to be reaching into the air and nasal cannula (NC-tubing that delivers oxygen through the nose) was found off of the resident's face.</p> <p>-2/3/2025- 9:04 AM- safe patient handling update- partial/moderate assistance of two with 4 wheeled walker with ambulation and transfers.</p> <p>-2/3/2025- 11:05 PM- resident mostly unresponsive this shift, did respond to tactile stimuli, not responding to verbal stimuli, did not take anything by mouth this shift.</p> <p>-2/4/2025- 4:29 PM- resident remains with oxygen (O2) at 2 liters (L) via NC with O2 saturation at 94 % (normal limits between 94-100%), independently sat on edge of bed.</p> <p>-2/4/2025- 4:53 PM- resident noted to have taken O2 off, O2 saturation of 77% on room air, O2 replaced at 2 L via NC with O2 saturation at 99%, resident responsive to tactile stimuli only, physician notified and new orders given for STAT (immediate) labs and a urinalysis with culture and sensitivity (a urine test conducted to identify the presence of an infection), grossly distended abdomen with pear shape. Urine difficult to obtain, results pending, lab results obtained and sent to physician.</p> <p>-2/4/2025- 9:11 PM- resident found to have sustained a fall this evening, it is presumed that s/he hit his/her head, family wishes to send resident out for an evaluation.</p> <p>-2/5/2025- 8:15 AM- resident admitted to hospital with hypercapnic respiratory failure (when there is too much carbon dioxide in the blood stream), pneumonia, and a urinary tract infection (UTI).</p> <p>Review of the January 2025 Medication Administration Record (MAR) revealed that the resident had not required the use of oxygen, during the month of January.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the February 2025 MAR revealed the resident was administered 2 L of oxygen for an O2 saturation of 88% on 2/1/2025. Further review failed to reveal documentation that the resident continued to receive O2 as indicated in the progress notes.</p> <p>Additional review of the February 2025 MAR revealed the following medications were not administered as ordered, with the documented reason being that the resident was unable to be aroused:</p> <ul style="list-style-type: none"> - Warfarin (a medication prescribed to prevent a blood clot) 2.5 milligrams (mg) once an evening, not administered on 2/3. - Aspirin 81 mg once a morning, not administered on 2/2 or 2/4. - Furosemide (a medication prescribed to decrease excess fluid in the body) 40 mg once a morning, not administered on 2/2 or 2/4. - Gentle Iron (a vitamin) once a day, not administered on 2/2 or 2/4. - Metoprolol Succinate Extended Release (a medication prescribed to lower blood pressure) 100 mg once a day, not administered on 2/2 or 2/4. - Polyethylene Glycol 17 grams (a laxative) once a morning, not administered on 2/2 or 2/4. <p>Record review failed to reveal evidence that the provider was notified that the resident did not receive any of the above medications on 2/2, 2/3 or 2/4/2025.</p> <p>Record review failed to reveal evidence that the provider was notified of the resident's change of condition including a mental status change until 2/4/2024, four days after the resident was first noted to be intermittently unarousable.</p> <p>Record review failed to reveal evidence that vital signs were obtained or documented on 1/31, 2/1, 2/2, or 2/3, following a documented change in the resident's condition.</p> <p>Record review of the hospital discharge paperwork dated 2/6/2025 revealed the resident was found to have possible pneumonia, a UTI and acute hypoxic (the lack of a sufficient supply of oxygen) and hypercarbic (when there is too much carbon dioxide in the blood) respiratory failure likely secondary to volume overload (a condition where you have too much fluid volume in your body), and pulmonary edema. Further review revealed the resident was transferred to hospice for end of life care following this hospital admission.</p> <p>During a surveyor interview on 2/19/2025 at 8:45 AM with Licensed Practical Nurse (LPN), Staff B, she revealed that she would expect Resident ID #2's physician to be notified if s/he was not responding to verbal stimuli, as the resident's baseline was to respond to verbal stimuli.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview on 2/19/2025 at approximately 1:30 PM with LPN, Staff A, she indicated that she worked on Resident ID #2's unit on 2/4/2025. Additionally she revealed that she was a per diem nurse and was unfamiliar with the resident, as that was the first time she was worked with him/her. She further revealed that she recalled being informed in report that the resident wasn't doing well and that the resident required a sternal rub (a sternal rub is performed by using the knuckles of a closed fist to firmly rub up and down on the sternum. This action creates a significant amount of discomfort or pain, which in a conscious person would elicit a response. The primary objective of this procedure is to determine the level of consciousness based on the patient's reaction to the stimulus) the day before. Furthermore she revealed that at the beginning of the shift she observed the resident having a conversation with his/her visitors, and that the next time she saw the resident s/he was on the floor bleeding from his/her knee and had a bump on his/her head. Lastly, she revealed that the resident's O2 saturation was approximately 70%, the resident's physician was then contacted, and the resident was transferred to the hospital via 911.</p> <p>During a surveyor interview on 2/19/2025 at 1:15 PM with the DNS, He revealed that Resident ID #2 passed away at an in-patient hospice facility on 2/7/2025.</p> <p>During a subsequent surveyor interview on 2/19/2025 at approximately 2:30 PM with DNS, he acknowledged that the documentation in the resident's medical record was lacking the appropriate information such as, physician notification and vital signs. He further indicated that the facility had discussed approaching the resident's family about hospice, but were also aware that the resident was still being seen by specialists, including hematology. Additionally, he could not provide evidence that the resident received the appropriate care including the identification of the resident's change in condition.</p> <p>During a surveyor interview on 2/20/2025 at 9:48 AM with the resident's physician, he indicated that he would expect to be notified of a resident's change in condition and if medications were missed. He further indicated that he believed a change in condition or that the resident was lethargic was mentioned to him. However he was unable to provide evidence that he was notified.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>46118</p> <p>Based on record review and staff interview, it has been determined that the facility failed to meet professional standards of quality relative to following physician's orders for 1 of 1 resident reviewed for the refusal of medications, Resident ID #2.</p> <p>Findings are as follows:</p> <p>According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states in part, .The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients .</p> <p>Review of a facility policy titled Medication Administration Safety Program (MASP)- Physician Notification states in part, .When a regularly scheduled dose of medication is not administered due to resident refusal, unavailability, resident condition or absence from the facility, the physician should be notified .</p> <p>Record review revealed the resident was admitted to the facility in November of 2024 with diagnoses including, but not limited to, heart disease, acute pulmonary edema (an abnormal buildup of fluid in the lungs), and reduced mobility.</p> <p>Review of the February 2025 Medication Administration Record (MAR) revealed the following medications were not administered on 2/2 and 2/4 as ordered:</p> <ul style="list-style-type: none"> - Aspirin 81 milligrams (mg) once a morning - Furosemide (a medication prescribed to decrease excess fluid in the body tissues) 40 mg once a morning - Gentle Iron (a vitamin) once a day - Metoprolol Succinate Extended Release (a medication prescribed to lower blood pressure) 100 mg once a day - Polyethylene Glycol 17 gram (a laxative) once a morning <p>Further review of the February 2025 MAR revealed the following medications were not administered on 2/3 as ordered:</p> <ul style="list-style-type: none"> - Warfarin (a medication prescribed to prevent a blood clot) 2.5 mg once an evening - Melatonin 3 mg at bedtime - Simvastatin (a medication prescribed to lower cholesterol) 10 mg once an evening - Trazodone (a medication prescribed for restlessness/agitation) 25 mg once an evening <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Zyprexa (a prescribed antipsychotic medication) 5 mg once an evening</p> <p>Record review failed to reveal evidence that the provider was notified that the resident did not receive the above medications on 2/2, 2/3 or 2/4/2025.</p> <p>During a surveyor interview on 2/19/2025 at approximately 9:00 AM with the Director of Nursing Services (DNS), he indicated that he would expect the physician to be notified of missed medications.</p> <p>During a subsequent surveyor interview with the DNS on 2/19/2025 at approximately 2:30 PM, he acknowledged that the documentation in the resident's medical record was lacking the appropriate information such as, physician notification.</p> <p>During a surveyor interview on 2/20/2025 at 9:48 AM with the resident's physician, he indicated that he would expect to be notified within 24 to 48 hours of a missed medication. Additionally, he could not recall if he had been made aware that the resident's did not receive all of his/her prescribed medications on 2/2, 2/3, and 2/4/2025.</p> <p>Cross reference F-580</p>