STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415080	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayberry Commons	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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and staff interview, it has been determined that the facility failed to provided services that meet professional standards of quality for 1 of 1 resident reviewed for a psychiatric recommendation that was not implemented, Resident ID #107. Findings are as follows: Record review revealed the resident was admitted to the facility in April of 2025 with diagnoses including, but not limited to, dementia and major depressive disorder. Record review revealed the resident was seen by psychiatric services on 6/3/2025 with a recommendation to increase sertraline (an antidepressant medication) to 50 milligrams (mg) once daily, due to inappropriate behaviors. Further review of the psychiatric documentation revealed a handwritten note which states Completed 6/11/25 with a staff signature.Record review revealed a progress note dated 6/3/2025 which states in part, Resident is alert and oriented at [his/her] baseline. Resident was seen by meditelecare and gave new recommendation for setraline [sic.] 50mg once a day due to inappropriate behaviors. [Resident ID #107's provider] approved new recommendation. Resident new order will be on hold due to family consent.Record review revealed a progress note dated 6/11/2025 which states, Call placed to POA [Power of Attorney] to alert of increase in Sertraline and to sign consent for psychotropic medication. Message left to return call.Record review failed to reveal evidence that the facility obtained consent or attempted to obtain consent from the resident's POA for the increased dose of sertraline after a phone call was placed on 6/11/2025.During a surveyor interview on 7/18/2025, with Licensed Practical Nurse, Staff A, he revealed that when there is an increase in a psychotropic medication, the facility will obtain consent from the resident representative, and indicated that when the consent is obtained, a consent form is completed and printed for the representative to sign. He revealed that the psychotropic medication would be on hold until consent is obtained and acknowledged that the resident's increased dose of sertraline was still on hold since the recommendation was made and approved by the provider on 6/3/2025. Further, he revealed that anytime the facility calls the resident representative to obtain consent, it should be documented in a progress note but was unable to provide evidence that the facility continued to attempt to obtain consent from the resident's POA after 6/11/2025.During a surveyor interview on 7/18/2025 at 9:35 AM, with the Director of Nursing Services, he revealed that nursing will receive the recommendation from the psychiatric provider, address it with the resident's provider, and if approved, they will obtain consent from the resident representative. He revealed that when consent is obtained, a form is to be completed and printed, so the resident representative can sign. Further, he revealed that he would expect nursing to inform the provider if consent was unable to be obtained and document their attempts in a progress note.During a surveyor interview on 7/18/2025 at 9:54 AM, with the resident's provider, he revealed that he was not aware the resident's sertraline increase was still on hold and indicated that as far as he knew, the resident had been receiving the 50 mg of sertraline daily. Further, he revealed that he was called on 6/3/2025 due to a psychiatric recommendation to increase the resident's sertraline, where he approved the recommendation due to the resident's history of depression, indicating he felt it would benefit the resident.

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and staff interview, it has been determined that the facility failed to ensure a resident's drug regimen was reviewed and acted upon by the attending physician, when irregularities were identified during the monthly Pharmacist Medication Regimen Review (MRR) for 3 of 5 residents reviewed, Resident ID #s 10, 92, and 107.Findings are as follows:Record review of a facility policy titled, CONTINUOUS QUALITY IMPROVEMENT OF THE MEDICATION USE PROCESS last revised January of 2023, states in part, The care center is responsible for monitoring the quality of the entire medication use process including, the.outcomes of consultant pharmacy services.1. Record review revealed Resident ID #10 was admitted to the facility in March of 2022 with diagnoses including, but not limited to, lower back pain and a wedged compression fracture of the first lumbar vertebra (a type of spinal compression fracture that forms on the front of the vertebra/back bone).Record review of a pharmacy consultant recommendation dated 5/2/2025 indicated that the lidocaine patch order needed to specify the area that the patch should be applied. Further record review failed to reveal evidence that the MRR irregularity recommendation was addressed since 5/2/2025 until it was brought to the facility's attention by the surveyor.2. Record review revealed Resident ID #92 was readmitted to the facility in April of 2025 with a diagnosis including, but not limited to, Alzheimer's disease. Record review of a pharmacy consultant note dated 4/4/2025, revealed the following recommendations:-Miralax (a laxative) recommendation: update order to use the provided cap to measure the dose accurately. Stir powder in 4 to 8 ounces of water, juice, soda, coffee or tea until dissolved. -Cholecalciferol (vitamin D3) 50,000 units weekly on Wednesday. Recommendation: discharged paperwork lists patient as taking Ergocalciferol (vitamin D2) 50,000 units. Please evaluate which vitamin D patient should be receiving.Record review of a pharmacy consultant note dated 7/3/2025, revealed a repeat of the above-mentioned recommendations were made.Further record review failed to reveal evidence the MRR irregularity recommendations were addressed since 4/4/2025, until it was brought to the facility's attention by the surveyor. 3. Record review revealed Resident ID #107 was readmitted to the facility in April of 2025 with diagnoses including, but not limited to, dementia, vitamin d deficiency, and folate deficiency anemia (a condition that occurs when you do not have enough B9 in your diet). Record review of a pharmacy consultant note dated 6/3/2025, revealed a recommendation to add appropriate diagnoses for the following medications: - Atorvastatin (a medication prescribed to treat high cholesterol) - Vitamin D - Vitamin B1 - Folic acidFurther record review failed to reveal evidence the MRR irregularity recommendation was addressed since 6/3/2025 until it was brought to the facility's attention by the surveyor. During surveyor interviews on 7/16/2025 at 1:49 PM and 7/17/2025 at 2:35 PM with the Director of Nursing Services, he revealed that it would be his expectation for the MRR to be addressed within 30 days. Additionally, he was unable to provide evidence that the pharmacy irregularity reports had been reviewed and acted upon by the physician.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to maintain medical records for all residents that are accurately documented in accordance with professional standards and practices for 1 of 2 residents reviewed with a physician's order for aspiration precautions (practices designed to prevent food, fluids, or secretions from entering the airway), Resident ID #112.Findings are as follows:Record review revealed the resident was readmitted to the facility in June of 2025 with diagnoses including, but not limited to, Alzheimer's disease and a history of dysphagia (impaired swallowing). Record review revealed a physician's order dated 6/23/2025, for aspiration precautions: head of bed elevated to 30 degrees, one staff to one resident for assistance with meals, oral care after eating, nectar thick fluids and a puree diet.Additional record review revealed a second physician's diet order dated 7/7/2025 for a house (regular texture) diet with thin liquids. During a surveyor observation on 7/15/2025 at 12:35 PM the resident was observed eating alone with thin liquids and a regular diet. Record review of the July 2025 Treatment Administration Record (TAR) revealed the order for aspiration precautions was signed during the day shift on 7/15/2025 by Licensed Practical Nurse (LPN), Staff B.Further review of the resident's July 2025 TAR revealed the order for aspiration precautions was signed off as completed three times a day, between 7/7/2025, when the house diet order was implemented, through 7/16/2025. During a surveyor interview on 7/16/2025 at 3:10 PM with LPN, Staff A, he revealed that the order for aspiration precautions was no longer active, indicating that s/he is currently prescribed a house regular diet and eats independently.During a surveyor interview on 7/16/2025 at 3:11 PM with Staff B, she acknowledged signing the aspiration precautions order without verifying the resident's diet on 7/15/2025 and indicated that she should not have. During a surveyor interview on 7/16/2025 at approximately 3:30 PM, with the Director of Nursing Services, he indicated that he would expect staff to document accurately.

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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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections, for 3 of 3 residents reviewed for transmission-based precautions (TBP) Resident ID #s 3, 91, and 105.Findings are as follows:Review of a facility policy titled, Guidelines for Management of MDROs [Multi-Drug Resistant Organism] states in part, .CONTACT PRECAUTIONS - In addition to Standard Precaution, Contact precautions or the equivalent used with specific individuals known or suspected to be infected or colonized with epidemiologically important micro-organisms that can be transmitted by direct contract with the individual or indirect contact with environmental surfaces or equipment. Contact precautions include proper resident placement, proper use of PPE [personal protective equipment], and proper environmental measures.ENHANCED BARRIER PRECAUTIONS - it has been determined by the CDC [Centers for Disease Control and Prevention] that focusing on residents with active infection fails to address the continued risk of transmission from residents with MDRO colonization, which can persist for long periods of time (e.g., months) and result in the silent spread of MDROs. Enhanced Barrier Precautions fall between Standard and Contact Precautions and requires gown and gloves for certain residents (both with existing MDROs, colonization of MDROs or those residents in close physical vicinity of those residents) during specific high contact care activities that have been found to increase the risk for MDRO transmission. Findings are as follows:1) Record review revealed Resident ID #3 was admitted to the facility in June of 2025 with diagnoses including, but not limited to, osteomyelitis (an infection in the bone) and a non-pressure ulcer of the right foot.Record review of an admission Minimum Data Set assessment dated [DATE] revealed the resident requires assistance with toileting and bathing.Record review revealed the resident has a peripherally inserted central catheter (PICC, a long, thin, flexible tube inserted into a vein in the upper arm and threaded into a larger vein near the heart). Additional record review revealed the resident has a non-pressure ulcer to the right foot with a KCl wound vac (a wound vacuum device that speeds up the healing process of a wound). During surveyor observations of the resident's doorway on the following dates and times failed to reveal signage indicating the resident is on EBP:- 7/15/2025 at 9:20 AM, 10:20 AM, and at 12:20 PM- 7/16/2025 at 8:39 AM, 10:45 AM and at 1:16 PM- 7/17/2025 at 8:21 AMDuring a surveyor observation on 7/16/2025 at approximately 10:00 AM, Registered Nurse, Staff C, was observed administering the resident his/her antibiotic via the PICC line, without wearing a gown. During a surveyor interview on 7/17/2025 at 10:20 AM with the Infection Preventionist, she acknowledged that this resident should have been on EBP and revealed that the signage for EBP had fallen off. B) Record review revealed Resident ID #91 was readmitted to the facility in June of 2025 with a diagnosis including, but not limited to, dementia.Review of a urinalysis dated 7/7/2025 revealed the resident tested positive for Extended Spectrum Beta Lactamase (ESBL, an MDRO) and Vancomycin Resistant Enterococci (VRE, an MDRO).Record review revealed a progress note dated 7/15/2025 which revealed the resident was being treated with Macrobid (an antibiotic medication), twice daily for 5-days, due to testing positive for ESBL and VRE. Further review revealed the resident will remain on contact precautions. During surveyor observations from 7/15/2025 through 7/18/2025, revealed signage and a PPE bin were posted outside Resident ID #91's doorway, which indicated that s/he was on contact precautions.Review of the contact precautions signage posted outside Resident ID #91's room revealed that providers and staff must put on gloves and gown before room entry and discard before room exit.During a surveyor observation on 7/17/2025 at 8:33 AM, two staff members were noted to be in Resident ID #91's room without a gown and gloves, preparing a breakfast tray for his/her roommate.During a surveyor interview on 7/17/2025 at 8:34 AM with Licensed Practical Nurse, Staff D, in the presence of Nursing Assistant, Staff E, she revealed that Staff E was on orientation and was still training. She further revealed that Resident ID #91 was on contact precautions due to a pending urinalysis but indicated contact precautions were only for Resident ID #91 and did not apply for his/her roommate. She acknowledged the signage posted outside Resident ID #91's room and acknowledged that based on the signage, they should have both worn a gown and gloves upon room entry.During a surveyor interview on 7/17/2025 at 10:02 AM, with the Infection Preventionist, she acknowledged that Resident ID #91 was on contact precautions and acknowledged that the signage posted indicated to wear PPE upon room entry.C) Record review revealed Resident ID #105 was readmitted to the facility in June of 2025 with a diagnosis including, but not limited to, respiratory failure