STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415081	A. Building B. Wing	06/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westerly Health Center	280 High Street Westerly, RI 02891

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to notify the Office of the State Long-Term Care Ombudsman, when a resident is hospitalized or discharged and return to the facility is not anticipated, for 2 out of 3 residents reviewed for facility discharges, Resident ID #s 117 and 119.Findings are as follows:1. Record review revealed Resident ID #117 was admitted to the facility in September of 2023. Additional review revealed s/he was transferred to and subsequently admitted to the hospital on [DATE].Review of the facility's March 2026 Ombudsman Notification Log failed to reveal evidence that Resident ID #117 was listed on the log.2. Record review revealed Resident ID #119 was admitted to the facility in March of 2026. Additional review revealed s/he was discharged to the community on 3/30/2026.Review of the facility's March 2026 Ombudsman Notification Log failed to reveal evidence that resident ID #119 was listed on the log.During a surveyor interview on 5/29/2026 at 12:30 PM with the Social Worker. Staff A, she acknowledged that Resident ID #s 117 and 119 were not listed on the Facility's March 2026 Ombudsman Notification Log.During surveyor interviews on 6/1/2026 at 1:55 PM and at approximately 4:05 PM, with the Director of Nursing Services, she was unable to provide evidence that the Ombudsman had been notified of the above-mentioned residents discharged in March 2026.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, and resident and staff interview, the facility failed to provide necessary services to residents who are unable to carry out activities of daily living (ADLs) relative to scheduled showers, for 2 of 2 residents reviewed who alleged that they were not provided their scheduled showers, Resident ID #s 54 and 81.Findings are as follows: Review of a facility policy last updated on 2/19/2024, titled Bathing and Showering states in part, .Residents have the right to choose health care schedules consistent with their preferences including bathing/showering.Residents will be provided with a shower .as per their preference.1. Record review revealed Resident ID #81 was admitted to the facility in November of 2024 with diagnoses including, but not limited to, major depressive disorder and unsteady gait.Record review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 out of 15, indicating the resident's cognition is intact. The MDS revealed that the resident requires extensive assistance for bathing/hygiene. Further review revealed that the resident's preference to receive a shower is very important.Review of a care plan dated 12/8/2024, revealed the resident has an ADL self-care performance deficit related to activity intolerance. Additional review of the care plan dated 1/29/2025 states s/he is to receive showers twice a week. Record review of a document titled 5 & 6 CNA (certified nursing assistant) list revealed, the resident is scheduled to receive showers twice weekly on Saturdays on the 7:00 AM to 3:00 PM shift and on Mondays on the 3:00 PM to 11:00 PM shift.Review of the documented shower's titled Task for Resident ID#81, revealed the resident was provided with a shower on 5/30/2026. Further review of the documentation revealed the resident had missed 7 scheduled showers in the last 30 days.During a surveyor interview on 5/27/2026 at 11:42 AM with Resident ID #81, s/he revealed that s/he has not been offered showers per his/her preference twice a week. 2. Record review revealed Resident ID #54 was admitted to the facility in March of 2026 with diagnoses including, but not limited to, major depressive disorder and difficulty walking.Record review of the admission MDS assessment dated [DATE], revealed a BIMS score of 9 out of 15, indicating the resident's cognition is moderately impaired. The MDS revealed that s/he requires extensive assistance for bathing/hygiene. Further review revealed that the resident's preference to receive a shower is very important.Review of a care plan dated 3/21/2026 revealed, the resident has an ADL self-care performance deficit related to impaired mobility.Record review of a document titled 5 & 6 CNA list revealed, the resident is scheduled to receive showers once a weekly on Sundays on the 7:00 AM to 3:00 PM shift.Record review of the documented shower's titled Task revealed that the resident did not receive any showers in the last 30 days. During a surveyor interview on 5/27/2026 at approximately 2:00 PM with Resident ID #54, s/he stated that it will be nice if staff would provide him/her their scheduled weekly shower.During a surveyor interview on 5/28/2026 at approximately 1:00 PM with Nursing Assistant, Staff B, she revealed that all the showers provided are documented under the resident's Task. However, review of the task documentation failed to reveal evidence that the resident had received any showers.During a surveyor interview on 6/1/2026 at 12:40 PM, with the Assistant Director of Nursing Services, she acknowledged that the Task documentation for Residents ID #54 and 81 failed to reveal evidence that both residents were offered their showers as scheduled per their preferred frequency.During a surveyor interview on 6/1/2026 at approximately 1:00 PM, with the Director of Nursing Services, she was unable to provide evidence that the residents were provided their showers as scheduled per their preference.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure a resident receives adequate supervision to prevent accidents for 3 of 5 residents reviewed who were identified as an elopement risk, Resident ID #s 15, 36, and 129. Findings are as follows:Record review of a facility policy titled Wander Management and Elopement Prevention last revised in November of 2025, states in part, .The facility will maintain the safety of residents who wander/or are at risk of elopement.5. When implementing a wander management system device, the staff will implement routine checks for placement and functionality.A. Wander management system device will be checked for placement each shift by nursing staff. B. Wander management system device will be checked daily for functionality by nursing staff.1. Record review revealed Resident ID #15 was originally admitted to the facility in April of 2026 with diagnoses including, but not limited to, Alzheimer's disease and dementia.Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 99, indicating the resident was unable to complete the assessment due to impaired cognition. Further review revealed the resident ambulates with supervision and uses a wander/elopement alarm daily.Record review of a care plan initiated on 4/29/2026 revealed, the resident is at risk for elopement due to a wandering episode, with an intervention for a wander management device to be placed on the resident. Record review of an Elopement/Wandering Risk Evaluation dated 5/16/2026 revealed, the resident is at high risk for potential wandering/elopement.Surveyor observations of the resident on 5/27/2026 at 12:56 PM, and on 5/29/2026 at 12:23 PM revealed, the resident ambulating independently on the secured unit wearing a wander management device.Record review failed to reveal evidence of physician's orders for the implementation of a wander management device which includes; checking its placement each shift and functionality daily.During a surveyor interview on 6/1/2026 at 12:43 PM with the Director of Nursing Services (DNS), she acknowledged that the resident did not have physician's orders in place for the implementation of a wander management device. Additionally, she would expect the physician's orders to include checking the device's placement each shift and its functionality daily.2. Record review revealed Resident ID #36 was admitted to the facility in February of 2026 with diagnoses including, but not limited to, Alzheimer's disease and dementia.Record review of an admission MDS assessment dated [DATE], revealed a BIMS score of 12 out of 15 indicating moderate cognitive impairment. Further review revealed the resident ambulates with supervision and uses a wander/elopement alarm daily.Record review of a care plan initiated on 2/26/2026 revealed, the resident is at actual or potential risk for elopement, with an intervention for the use of a wander management device.Record review revealed the following physician's orders: -Check placement of the wander bracelet twice every 4 hours for safety, initiated on 3/3/2026.- Monitor for behaviors of exit seeking/packing belongings each shift, initiated on 3/7/2026.Record review of the May 2026 Medication Administration Record revealed exit seeking behaviors were documented on 5/5, 5/11, and 5/17/2026.Further review failed to reveal evidence of a physician's order to check the functionality of the wander management device.Surveyor observations of the resident on 5/27/2026 at 12:51 PM, 5/28/2026 at 9:26 AM, and 6/1/2026 at 10:29 AM, revealed s/he was ambulating independently on the secured unit wearing a wander management device.During a surveyor interview on 6/1/2026 at 12:43 PM with the DNS, she acknowledged that there was not a physician's order in place to check the functionality of the wander management device daily and would expect one to be in place.3. Record review revealed Resident ID #129 was admitted to the facility in May of 2026 with diagnoses including, but not limited to, dementia and adjustment disorder.Record review of an Elopement/Wandering Risk Evaluation dated 5/22/2026, revealed the resident is at risk for potential wandering/elopement.Record review revealed a physician's order dated 5/22/2026 to check (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	placement of the wander management device every shift.Further review failed to reveal evidence the physician's order to check the functionality of the wander management device daily was implemented.Record review of the progress notes revealed, on 5/22/2026 the resident was walking independently without a rolling walker, presented with exit seeking behaviors, and a wander management device was placed on the resident. Further review of the progress notes revealed that on 5/25/2026, the resident was observed to pack his/her belongings in a bag and run down the hall after a family member as they were attempting to leave the secure unit. The resident stated, s/he wanted to go home.Surveyor observation on 5/27/2026 at 1:36 PM revealed the resident ambulating independently in his/her room on the secured unit wearing a wander management device.During a surveyor interview on 6/1/2026 at 12:43 PM with the DNS, she acknowledged that there was not a physician's order in place to check the functionality of the wander management device daily.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on clinical record review and staff interview, the facility failed to provide appropriate treatment and services for 2 of 3 residents reviewed with an indwelling urinary catheter (a flexible tube that collects urine from the bladder and empties into a drainage bag) related to urine output monitoring, for Resident ID #s 6 and 103.Findings are as follows:According to Brunner & Suddarth's Textbook of Medical-Surgical Nursing Volume 2, 10th Edition, page 1282 states, For patients with indwelling catheters, the nurse assesses the drainage system to ensure that it provides adequate urinary drainage. The color, odor, and volume of urine are also monitored. An accurate record of fluid intake and urine output provides essential information about the adequacy of renal function and urinary drainage.1. Record review revealed the Resident ID #6 was admitted to the facility in September of 2024 with a diagnosis including, but not limited to, urinary retention.Record review of a care plan initiated on 10/16/2025 revealed that the resident has an indwelling urinary catheter.Record review revealed the following physician's orders:- Provide urinary catheter care every shift with a start date of 2/24/2025- Change indwelling foley catheter on the 21st of each month with a start date of 11/11/2025 Further record review failed to reveal evidence of an order to monitor for color, odor, and urine output to adequately monitor renal function and urinary drainage.2. Record review revealed Resident ID# 103 was admitted to the facility in May of 2026 with a diagnosis including, but not limited to, type 2 diabetes mellitus.Record review of a care plan initiated on 5/13/2026 revealed that the resident has an indwelling urinary catheter.Record review revealed the following physician's orders:- Provide urinary catheter care every shift with a start date of 5/12/2026- Measure urinary output every shift and document the output in milliliters with a start date of 5/12/2026Record review of the Medication Administration Record for May 2026 revealed that the facility failed to document urine output for 10 of 59 opportunities, as ordered, to adequately monitor renal function and urinary drainage. Representing approximately a 17% failure rate to monitor. During a surveyor interview on 6/1/2026 at 1:28 PM, with the Director of Nursing Services, she acknowledged that Resident ID #6 did not have an order to monitor for urinary output and should have. Additionally, she acknowledged that the facility failed to accurately monitor urinary output for Resident ID #s 6 and 103.

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	415081	A. Building B. Wing	06/01/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to store all drugs and biologicals in accordance with currently accepted professional principles for 1 of 1 resident found with medication in his/her room, Resident ID #27, 1 of 3 medication carts, and 2 of 2 medication storage rooms.Findings are as follows:Record review of a facility policy titled Medication labeling and storage revealed in part, .If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems.The medication label include, at a minimum.the expiration date, when applicable.resident's name.multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.Record review of a facility policy titled Administering Medications revealed in part, .The expiration/beyond use date on the medication label is checked prior to administering.1) Record review revealed Resident ID# 27 was admitted to the facility in March of 2022 with a diagnosis including, but not limited to, anxiety disorder.Record review revealed a physician's order dated [DATE] for diazepam (a medication prescribed to treat anxiety) 2 milligrams (mg) give 1/2 tablet (1 mg) twice daily.During a surveyor observation on [DATE] at 8:51 AM the resident revealed that s/he had three 1/2 tablets and one 1/4 tablet of diazepam in his/her room.During a surveyor interview and observation on [DATE] at 9:10 AM in the resident's room, in the presence of Registered Nurse (RN), Staff C, the resident provided the pills to the RN. Staff C acknowledged that the resident should not have the pills in his/her room.During a surveyor interview on [DATE] at 2:25 PM with the Director of Nursing Services (DNS), she acknowledged that the resident should not have the pills in his/her room.2) During a surveyor observation of the team two medication cart on the first floor in the presence of Medication Technician, Staff D, the following was revealed:-One Lidocaine 1% 200 mg/20 milliliter (ml) multi-dose bottle opened, and undated, with no resident name on the bottle.During a surveyor interview with Staff D at the time of the above observation, she acknowledged that the bottle failed to have a resident's name, and it was opened and undated.3a) During a surveyor observation of the second-floor medication room on [DATE] at 10:37 AM in the presence of Registered Nurse, Staff E, the following was revealed:- Two 2-ounce boxes of Good Sense hemorrhoidal ointment which expired on 8/2025.- Two bottles of Aspirin 325 mg which expired in 12/2025- One bottle of lorazepam 2mg/ml opened and undated. The manufacturer's instructions on the box state to discard the open bottle 90 days after opening.During a surveyor interview immediately following the observation, Staff E acknowledged that the above medications were expired and should have been discarded, and that the Lorazepam was opened and undated. She further revealed that she was unable to get into the other locked box which contained more lorazepam bottles.3b) During a surveyor observation of the second locked box in the second-floor medication room on [DATE] at 10:56 AM, in the presence of Licensed Practical Nurse (LPN), Staff F, the following was revealed:- Two bottles of lorazepam 2mg/ml opened and undated. The manufacturer's instructions on the boxes state to discard the open bottle 90 days after opening.- One bottle of lorazepam 2 mg/ml which was wet to the touch, opened and undated. This bottle failed to have a resident name that was able to be read, there was tape on the bottle, but it was illegible.During a surveyor interview at the time of the above observation, Staff F acknowledged that the three bottles of Lorazepam were opened and undated. She further acknowledged that the third bottle was wet with no legible resident name on the bottle.4) During a surveyor observation of the first-floor medication room on [DATE] at 11:14 AM, in the presence of LPN, Staff G, the following was revealed:- One bottle (continued on next page)

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	415081	A. Building B. Wing	06/01/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of Lorazepam 2mg/ml opened and undated. The manufacturer's instructions on the box state to discard the open bottle 90 days after opening.During a surveyor interview at the time of the above observation, Staff G acknowledged that the Lorazepam was opened and undated.During a surveyor interview on [DATE] at 1:10 PM with the DNS, she revealed that the lidocaine vial and the Lorazepam should have been labeled with a resident's name, and that all the above medications should have been dated when opened. She further revealed that the expired medication should have been discarded based on the expiration dates.

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	415081	A. Building B. Wing	06/01/2026

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, and resident and staff interviews, the facility failed to provide reasonable accommodation of resident needs and preferences, for 1 of 1 resident reviewed related to providing an electric wheelchair to maintain comfort during independent mobility, Resident ID #44 who has bilateral lower extremity amputations. Findings are as follows:Record review revealed the resident was admitted to the facility in September of 2023 with diagnoses including, but not limited to, muscle weakness and absence of the right and left lower leg, below the knees.Review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status score of 15 out of 15, indicating the resident is cognitively intact. Further review revealed that the resident is independent with a slide board transfer (a mobility aid that helps individuals with limited mobility transfer from one surface to another), and the use of a manual wheelchair.Record review of a care plan initiated on 11/10/202,3 for potential for pain, revealed an intervention to refer to Physical Therapy and/or Occupational Therapy, as needed.Record review of an Occupational Therapy (OT) Evaluation and Plan of Treatment dated 3/31/2026, revealed that the resident was evaluated and complained of bilateral shoulder pain. Additionally, the resident feels that a power wheelchair may help with his/her shoulder pain. Further review of the OT evaluation failed to reveal evidence recommendations for a power wheelchair were made or that the bilateral shoulder pain was addressed.During a surveyor interview on 5/27/2026 at 9:12 AM with the resident, s/he revealed that s/he transfers via a slide board independently and self-propels in his/her manual wheelchair. Additionally, s/he experiences pain in his/her bilateral shoulders due to lifting his/her body and pushing the wheels of the wheelchair throughout the day. The resident indicated s/he had spoken to the facility staff about obtaining a power wheelchair but has not heard back.Record review of a Radiology Results Report dated 4/21/2026, revealed that x-rays were obtained with results indicating Osteoarthritis (a form of arthritis that occurs with the protective cartilage that cushions the ends of the bones wears down overtime, leading to pain, stiffness, and reduced mobility) of the right and left shoulder and shoulder joints.Record review of a progress note dated 4/21/2026, authored by the Nurse Practitioner (NP), Staff H, revealed the resident was seen by the NP secondary to bilateral shoulder pain and discomfort with known osteoarthritis. The resident consulted with the facility's orthopedic provider and the provider recommended bilateral shoulder x-rays to compare with previous x-rays, from roughly 2 years ago. Additionally, the progress note revealed the findings of arthritis of the bilateral shoulders and shoulder joints. Further review indicated the resident continued to endorse pain and discomfort. S/he is wheelchair-bound and constantly utilizing both arms to get around; this is suspected to be increasing his/her pain and arthritis from overuse. Furthermore, the progress note revealed the provider will collaborate with the orthopedic provider regarding the findings of the x-rays.Record review of a progress note dated 4/30/2026, authored by the Orthopedic Provider, Staff I, revealed the resident complains of chronic pain to his/her shoulders which s/he thinks may be because of using his/her wheelchair to mobilize. She/he notes constant aching in the shoulders which seems to be worsened by overuse. Additional review revealed she/he is requesting use of a power wheelchair and this would be a reasonable accommodation.Record review of a facility provided document titled Orthopedic Program Rounds dated 5/14/2026, revealed a recommendation from the provider for use of a powered wheelchair, three days per week.During surveyor interview with the Director of Nursing Services on 5/31/2026 at 1:55 PM, she acknowledged that she was aware that the resident was requesting an accommodation of a motorized wheelchair secondary to bilateral upper extremity pain. Additionally, she was unable to provide evidence that the facility followed up and/or provided such accommodation.

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	415081	A. Building B. Wing	06/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure that the assessment accurately reflected the resident's status for 1 of 2 residents reviewed related to smoking, Resident ID #62, and 1 of 3 residents reviewed related to a misspelled name, Resident ID #38.Findings are as follows:1) Record review revealed Resident ID# 62 was admitted to the facility in July of 2023, with diagnoses including, but not limited to, major depressive disorder and anxiety disorder. Record review of a physician's order dated 3/13/2025, revealed the resident may smoke with staff up to 4 times per day. It further revealed all smoking materials were to be locked in the nursing cart, and a smoking apron must be worn.Review of a smoking safety evaluation dated 6/4/2025, revealed the resident currently smokes cigarettes, 2-3 times daily.Review of an Annual Minimum Data Set (MDS) assessment dated [DATE], revealed O was coded for Section J1300, indicating that the resident does not currently use tobacco products.2) Record review revealed Resident ID #38 was admitted to the facility in December of 2025, with diagnoses including, but not limited to, congestive heart failure and dementia.Review of Resident ID #38's Entry MDS dated [DATE], revealed the resident's name was misspelled in Section A6500, Last Name. Review of an admission MDS, dated [DATE], found this resident's name spelled correctly, though the Entry MDS was not revised with the correct name.During a surveyor interview on 5/29/2026 12:03 PM, with the Regional MDS Coordinator, she acknowledged that the MDS assessments mentioned above were inaccurately coded. She further acknowledged Resident ID #62 should have been coded that the resident does currently use tobacco products, and Resident ID #38's name should have been corrected on the Entry MDS.During a surveyor interview on 5/29/2026 at 1:17 PM, with the Director of Nursing Services, she indicated that she would expect the MDS assessments to accurately reflect the resident's status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415081	A. Building B. Wing	06/01/2026

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on clinical record review and staff interview, the facility failed to develop and implement a baseline care plan, for 1 of 1 newly admitted resident identified as an elopement risk, Resident ID #129.Findings are as follows:Record review revealed the resident was admitted to the facility in May of 2026 with diagnoses including, but not limited to, dementia and adjustment disorder.Record review of an Elopement/Wandering Risk Evaluation dated 5/22/2026, revealed the resident is at risk for potential wandering/elopement.Record review of progress notes revealed that on 5/22/2026, the resident was walking independently without a rolling walker, presented with exit seeking behaviors and a wander management device was placed on the resident. Further review of progress notes revealed that on 5/25/2026, the resident was observed to pack his/her belongings in a bag and run down the hall after a family member as they were attempting to leave the secure unit, the resident stated s/he wanted to go home.Record review failed to reveal evidence of a completed baseline care plan, initiated within 48 hours after admission, which included interventions for an identified elopement risk. During a surveyor interview on 6/1/2026 at 12:42 PM with the Director of Nursing Services, she revealed it was her expectation the resident's identified elopement risk would have been included in his/her baseline care plan.

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	415081	A. Building B. Wing	06/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westerly Health Center	280 High Street Westerly, RI 02891

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on clinical record review and staff interview, the facility failed to ensure that the comprehensive care plan was reviewed and revised by the interdisciplinary team, for 1 of 2 residents reviewed, Resident ID #44.Findings are as follows:Record review revealed Resident ID# 44 was admitted to the facility in August of 2023, with a diagnosis including, but not limited to, Chronic Obstructive Pulmonary Disease.Record review revealed a Physician's order dated 4/9/2026, indicating that the resident may smoke up to four times per day and all smoking implements must be stored in the medication cart.Review of the resident's comprehensive care plan dated 10/7/2025, revealed an intervention including, but not limited to, the resident may store all smoking materials in his/her room. Further review failed to reveal evidence the care plan was revised after the order was given for nursing to store all smoking implements in the medication cart.During a surveyor interview on 5/29/2026 at 1:18 PM with the Director of Nursing Services, she acknowledged that the care plan failed to be revised and should have been.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, staff and resident representative interviews, it has been determined that the facility failed to ensure that a resident receives proper treatment to maintain hearing abilities for 1 of 1 resident reviewed for hearing concerns, Resident ID #46. Findings are as follows:Record review revealed the resident was admitted to the facility in May of 2023 with diagnoses including, but not limited to, mild cognitive impairment and major depressive disorder.Record review of a care plan dated 8/7/2024 states the resident is hard of hearing related to the aging process with an intervention to provide him/her with appropriate hearing aids as required and a goal to be able to communicate effectively with staff with dignity.Record review of the Quarterly Minimum Data Set assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 7 out of 15, indicating the resident's cognition is severely impaired. Further review of the MDS revealed that his/her ability to hear is highly impaired.1a) During a surveyor interview on 5/27/2026 at 11:12 AM with the resident, s/he was unable to hear, s/he stated, I can't hear anything that you are saying.Review of a physician's order dated 3/20/2026 revealed Debrox (a medication to soften the earwax before its removal) Solution 6.5% to instill 5 drops in both ears twice a day for 4 days related to earwax. Record review of March of 2026 Medication Administration record failed to revealed evidence that the resident received the Debrox Solution on the following days and times: 3/20/2026 - 8:00 PM 3/21/2026 - 8:00 AM 3/21/2026 - 8:00 PM This indicates that s/he missed 3 doses out of 8 opportunities. 1b) During a surveyor observation on 5/28/2026 at 12:19 PM, the resident was observed in his/her room with no evidence of a hearing aid.Record review failed to reveal evidence of the resident receiving any hearing device per his/her plan of care.During a surveyor interview following the observation with Nursing Assistant, Staff K, she revealed that the resident is hard of hearing however, s/he has an amplifier that was brought by a family member to help communicate with the resident. Additionally, Staff K was observed taking the amplifier out of the resident's drawer then applying it to the resident's ears. Further the resident was observed smiling saying thank you, now I can hear. Further, Staff K was unable to explain why the amplifier was not applied to the resident prior to being brought to her attention by the surveyor.During a surveyor interview on 5/28/2026 at 12:31 PM with Registered Nurse Staff L, she acknowledged that the resident is hard of hearing. Additionally, she stated that she was unaware that the resident had an amplifier. When Staff L was asked why the amplifier was not being applied to the resident, she acknowledged that there is no order to apply it.During a surveyor interview on 5/28/2026 at approximately 1:00 PM, with the Director of Nursing Services, she was unable to provide evidence that the resident received the Debrox solution as ordered. Additionally, she revealed that she was not aware of the amplifier usage by the resident as she was unable to provide evidence of a physician's order.During a surveyor interview on 5/28/2026 at approximately 2:00 PM with the provider, he revealed that he would have expected the resident to receive the Debrox Solution as ordered. Additionally, he indicated that he was not made aware of the amplifier application to the resident. Further, he indicated that he would expect the staff to notify him to obtain an order for the hearing device per the resident's plan of care.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, resident, and staff interview, the facility failed to ensure a resident with limited range of motion (ROM) received appropriate treatment and services to increase ROM and/or to prevent further decrease in ROM for 1 of 1 resident reviewed, Resident ID #10. Findings are as follows:Record review revealed Resident ID #10 was readmitted to the facility in June of 2025 with diagnoses including, but not limited to, right femur fracture, difficulty walking and chronic pain.Record review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. Further review revealed the resident had impaired range of motion of both sides of his/her lower extremities.Review of the comprehensive care plan dated 1/7/2026, revealed the resident had a right hip fracture related to a fall, with identified care plan interventions that included, but were not limited to, monitoring, documenting, and reporting signs and symptoms of fracture-related complications to the physician, including contracture formation; ongoing assessment and evaluation of the resident's need for adaptive devices; and consultation with Physical Therapy to address functional limitations and promote mobility.During a surveyor observation and simultaneous interview on 5/27/2026 at 11:53 AM, the resident was observed sitting in his/her wheelchair. His/her bilateral feet were observed to be maintained in a pronounced plantar-flexed position (a position where the feet and toes are pointing downward). The resident revealed that s/he has been discharged from therapy and wanted to continue service to improve his/her mobility.Record review revealed the resident received Physical Therapy Services from 3/24/2026 through 5/19/2026.Record review of a Physical Therapy Encounter Treatment Note dated 5/16/2026, revealed a planned discharge date of 5/19/2026. The treatment note documented a recommendation to obtain a plantar flexion contracture splint (a device designed to maintain proper positioning and alignment of an extremity to preserve or improve joint mobility) to address the resident's plantar flexion of his/her bilateral feet and promote dorsiflexion of the foot (movement of the foot upward toward the shin).Record review of the PT Discharge Summary dated 5/19/2026, revealed discharge recommendations to acquire the plantar flexion (PF) contracture boots.During an interview conducted on 6/1/2026 at 11:01 AM, with the Director of Rehabilitation, she acknowledged that the resident was discharged from Physical Therapy services on 5/19/2026 with a recommendation for PF contracture boots. She revealed that the recommended boots required a vendor appointment for assessment and custom fitting. She further acknowledged that it was her responsibility to follow up and arrange the appointment to obtain the recommended device. However, she acknowledged that, as of 6/1/2026, no appointment had been scheduled and no follow-up action had occurred, approximately 15 days after the recommendation was made.During an interview conducted on 6/1/2026 at 1:55 PM, the Director of Nursing Services acknowledged she was not aware that the resident had a Physical Therapy discharge recommendation for PF contracture boots related to limited range of motion of the lower extremities. She stated she would have expected that such a recommendation would have been communicated to nursing staff at the time it was made to ensure appropriate follow-up and coordination of care.During a surveyor interview on 6/1/2026 at 2:10 PM with the Medical Director, he indicated that typically there would be communication from therapy to nursing to obtain an order for the PF contracture boots. Additionally, he indicated he would expect the facility to follow up within approximately a two-week time frame to obtain an appointment for the fitting of the contracture boots.

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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. Based on clinical record review and staff interview, the facility failed to ensure that residents are free from significant medication errors for 1 of 1 resident reviewed for the administration of an intramuscular antibiotic (a medical procedure where the medicine is delivered directly into the muscle tissue), Resident ID #64.Findings are as follows:Record review of the facility policy titled, Administering Medications states in part, .Medications are administered in a safe and timely manner, and as prescribed.Medications are administered in accordance with prescriber orders, including the required time frame.Record review revealed the resident was admitted to the facility in September of 2025 with a diagnosis, including but not limited to, chronic kidney disease.Record review of a lab report revealed a urine specimen was obtained on 5/21/2026. This lab report indicated that on 5/25/2026 a report was sent to the facility that the resident tested positive for a urinary tract infection, and that the organism could be treated with Ertapenem (an antibiotic prescribed to treat urinary tract infections).Record review revealed a physician's order dated 5/25/2026 for Ertapenem sodium injection solution 1 Gram (GM) intramuscularly, for urinary tract infection, for 5 days. This order had a start date of 5/25/2026 and continued through 5/29/2026, indicating that 5 doses should have been given to the resident.Record review of the facility provided Packing slip Proof of Delivery from the pharmacy, revealed that 5 doses of Ertapenem were delivered for the resident, 3 doses on 5/25/2026 and 2 doses on 5/27/2026.Record review of the May Medication Administration Record revealed that the Ertapenem was not signed off as administered on 5/27/2026.During a surveyor observation of the medication cart on 6/1/2026 at 10:38 AM, with Registered Nurse, Staff L revealed two doses of Ertapenem in the medication cart with the resident's name on them.During the above observation Staff L acknowledged that the Ertapenem was not signed off as administered on 5/27/2026. She further acknowledged the unopened dosages left in the medication cart for the resident.During a surveyor interview on 6/1/2026 at approximately 1:30 PM with the Director of Nursing Services, she was unable to provide evidence that any Ertapenem, beyond the 5 doses listed above, had been obtained for the resident. Additionally, she was unable to explain how the resident received the 5 doses that were ordered by the physician if there were 2 doses remaining in the medication cart.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on record review and staff interview, the facility failed to establish an Infection Prevention and Control Program (IPCP) that must include, at a minimum, an antibiotic stewardship program which includes antibiotic use protocols and a system to monitor antibiotic use to ensure that residents who require an antibiotic, are prescribed the appropriate antibiotic for 2 of 4 residents reviewed for antibiotic use, Resident ID #s 10 and 64. Findings are as follows:According to the Centers for Disease Control and Prevention (CDC) document titled, The Core Elements of Antibiotic Stewardship for Nursing Homes states in part, Perform antibiotic 'time outs.' .Nursing homes should have a process in place for a review of antibiotics by the clinical team two to three days after antibiotics are initiated to answer these key questions: Does this resident have a bacterial infection that will respond to antibiotics? If so, is the resident on the most appropriate antibiotic(s), dose, and route of administration? Can the spectrum of the antibiotic be narrowed or the duration of therapy shortened (i.e., de-escalation)? Would the resident benefit from additional infectious disease/antibiotic expertise to ensure optimal treatment of the suspected or confirmed infection . 1. Record review revealed that Resident ID #10 was readmitted to the facility in March of 2026 with a diagnosis including, but not limited to, elevated white blood cell count.Record review revealed a physician's order dated 5/21/2026 for Amoxicillin Pot Clavulanate (an antibiotic) tablet 875-125 milligrams (mg) every 12 hours for 7 days, from 5/21/2026 through 5/28/2026.Record review revealed an antibiotic time out form was initiated on 5/23/2026 but was not completed.2. Record review revealed that Resident ID #64 was admitted to the facility in September of 2025 with a diagnosis including, but not limited to, chronic kidney disease.Record review revealed a physician's order dated 5/25/2026 for Ertapenem Sodium (an antibiotic) injection 1 Gram daily for 5 days, from 5/25/2026 through 5/29/2026.Record review failed to reveal evidence that an antibiotic time out was completed.During a surveyor interview on 6/1/2026 at approximately 1:15 PM with the Director of Nursing Services, she was unable to provide evidence that antibiotic time outs were completed for the above two residents who were receiving antibiotics.