STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415084	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmhurst Rehabilitation and Healthcare Center	50 Maude Street Providence, RI 02908

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, and staff interview the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice relative to the care of a central venous catheter (CVC, a long thin tube that is inserted through a vein and passed through to the larger veins into the heart), for 3 of 3 residents reviewed with a CVC, Resident ID #s 23, 161, and 206, and for 1 of 1 resident reviewed for mouth care, Resident ID #2. Findings are as follows:According to Lippincott Nursing Procedures, Ninth Edition page 657, states in part, .Performing a CVC dressing change .Use a sterile measuring tape or the incremental markings on the catheter to measure the external length of the catheter from hub to skin entry to make sure that the catheter hasn't migrated .Review of a facility policy titled, Central Venous Catheter Care and Dressing Changes dated October 2024 states in part, .Measure the length of the external central vascular access device with each dressing change or if catheter dislodgement is suspected. Compare with the length documented at insertion.Change the dressing if it becomes damp, loosened or visibly soiled and at least every 7 days.For PICCs [a PICC, a long, flexible catheter that is inserted into a vein in the upper arm. After insertion, the catheter is threaded to a central vein near the heart. The PICC line can be used to deliver fluids and medications], measure arm circumference and compare to baseline when clinically indicated to assess for edema and possible deep- vein thrombosis [DVT- a blood clot (thrombus) that forms in one or more of the deep veins in the body] .1a. Record review revealed that Resident ID #23 was admitted to the facility on [DATE] with a diagnosis including, but not limited to, bacterial pneumonia.Record review of a hospital document titled PICC insertion Record dated 12/31/2025, revealed the resident had a PICC placed in his/her left arm. The baseline external length of the catheter was 0 centimeters (cm), and the baseline arm circumference was 36 cm.Record review revealed a physician's order dated 1/3/2026 to change the PICC dressing on admission and then every 7 days. Further record review failed to reveal evidence that the PICC dressing was changed on admission per the physician's order and the facility policy. Record review revealed a physician's order dated 1/4/2026 to document the baseline mid-upper arm circumference, check arm circumference (a measurement used to monitor for a deep vein thrombosis (DVT, a blood clot) as needed one time only on 1/4/2026.Review of the Medication Administration Record (MAR) for January 2026 revealed the above order to check the arm circumference was completed on 1/4/2026 with an arm circumference of 41 cm, indicating a 5 cm increase from the hospital's measurement. Record review revealed a physician's order dated 1/3/2026 to document the baseline external length of the intravenous (IV) catheter, check external length with each dressing change and as needed in the evening every 7-day(s) and document the external length.Review of the MAR for January 2026 revealed that the above order to check the external length was completed on 1/6/2026 with a documented external length of 7 cm, indicating a 7 cm increase from the hospital's measurement. Record review failed to reveal evidence that the provider was notified that the arm circumference measurement was 5 cm greater than the baseline arm circumference and that the PICC line was documented as migrating 7 cm on 1/6/2026 (displacement of the tip of the catheter from the intended position, increasing the risk for complications such as clot development, infection and vessel (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oral infection.moisten the applicators with the mouthwash solution.Thoroughly wipe the roof of the resident's mouth, inside the cheeks, the tongue, and the teeth with the applicator.Record review revealed Resident ID #2 was admitted to the facility in May of 2023 with diagnoses including, but not limited to, cerebrovascular disease (a group of conditions that affect blood flow to the brain) and adult failure to thrive.Record review revealed a physician's order dated 10/10/2024 indicating s/he receives nothing by mouth. Additionally, s/he receives enteral nutrition (a method of delivering liquid nutrition directly into the stomach) via a gastrostomy tube (G-tube-a tube inserted through the abdominal wall directly into the stomach used to provide nutrition, hydration and medications for residents that are unable to take food or fluids by mouth).Review of a care plan focus area dated 6/26/2025 revealed s/he has self-care performance deficits and is dependent on staff for personal hygiene and requires assistance with oral care.Further review revealed the following physician's orders pertaining to oral hygiene:-11/10/2023: Mouth care two times each shift-12/4/2023: Biotene artificial saliva apply 2 swabs orally every 4 hours for mouth careReview of an annual oral exam assessment dated [DATE] revealed the resident's tongue appeared pink. Additionally, it revealed the tongue was documented as not coated.Surveyor observations revealed the resident's tongue had a thick brown, fuzzy coating that appeared hardened, blackish brown matter on his/her upper and lower teeth, and malodorous breath on the following dates and times:-1/12/2026 at 10:12 AM-1/13/2026 at 12:20 PM, 2:29 PM, 3:13 PM, and 3:48 PMDuring a surveyor interview immediately following the observation on 1/13/2026 at 3:48 PM with Licensed Practical Nurse, Staff F, she acknowledged the thick brown coating on the resident's tongue and the buildup of blackish brown matter on the resident's upper and lower teeth. She revealed that she has been working at the facility since July of 2025 and indicated the resident's tongue and oral cavity has always appeared that way. She further revealed that she feels mouth care should be completed more than what is ordered, however has not informed the provider. She revealed that she already completed mouth care for the resident earlier in the day at approximately 8:45 AM and 11:45 AM. When the surveyor inquired how she conducts mouth care, she revealed she only utilizes the Biotene solution and a mouth swab. Staff F failed to indicate that she utilizes mouthwash to clean the resident's oral cavity. Further, Staff F acknowledged the resident's malodorous breath that was noticeable to the surveyor despite wearing a surgical mask.During surveyor interviews on 1/14/2026 at approximately 11:10 AM and 12:00 PM with the Nurse Practitioner, Staff E, she revealed that she would expect staff to be providing mouth care according to the facility policy to cleanse the resident's mouth in addition to the applying the Biotene solution.During a surveyor interview on 1/14/2026 at approximately 3:00 PM with the DNS, she revealed that she expects proper mouth care to be completed as ordered.During a surveyor observation on 1/15/2026 at approximately 9:30 AM, the resident's teeth and oral cavity appeared clean, his/her tongue pink and without a coating, and his/her breath without a noticeable foul odor after the concern was brought to the facility's attention by the surveyor.

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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 clinical record review, resident and staff interview, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 3 of 3 residents reviewed for not following physician's orders, Resident ID #s 2, 17 and 208. Findings are as follows:1) Record review revealed Resident ID #2 was admitted to the facility in November of 2023 with a diagnosis including, but not limited to, cerebrovascular disease (a group of conditions that affect blood flow to the brain). Further review revealed the resident has a gastrostomy tube (G-tube-a tube inserted through the abdominal wall directly into the stomach used to provide nutrition, hydration and medications for residents that are unable to take food or fluids by mouth). Record review revealed a physician's order dated 4/14/2025 to flush the g-tube with 50 milliliters (ml) of water after medications, and feedings.During a surveyor observation on 1/14/2026 at 9:45 AM, during the medication administration task, Licensed Practical Nurse (LPN), Staff A, flushed the resident's g-tube with 30 ml of water after administering the resident his/her medications, instead of 50 ml of water, per the physician's order.During a surveyor interview on 1/14/2026 at 1:45 PM, with Staff A, she acknowledged that she did not flush the g-tube with 50 ml of water and revealed that she should that per the physician's order. During a surveyor interview on 1/14/2026 at 3:00 PM, with the Director of Nursing Services (DNS), she revealed that it is her expectation that the physician's orders are followed. 2) Review of a policy dated 4/2019 titled, Administering Medications, states in part, .Medications are administered in a safe and timely manner, and as prescribed.Medications are administered within one (1) hour of their prescribed time.Record review revealed that Resident ID #17 was readmitted to the facility in December of 2025, with a diagnosis including, but not limited to, Parkinsons disease.Record review revealed a care plan dated 11/11/2025, which revealed the resident is on antiparkinsonian therapy, with an intervention to administer medications as ordered.Record review revealed the following physician orders:- Rytary (a medications prescribed to treat Parkinson's disease) Oral Capsule Extended Release 36.25-145 milligrams (mg), with instructions to administer 2 capsules by mouth, two times a day, at 8:30 AM and 4:30 PM for Parkinsons disease.- Rytary Oral Capsule Extended Release 36.25-145 MG, with instructions to administer 3 capsules by mouth, two times a day, at 5:00 AM and 12:30 PM for Parkinsons disease.Review of the December 2025 Medication Administration Record (MAR), under the section titled, Administration Details revealed the following:- 12/29: 12:30 PM dose administered at 2:16 PM- 12/29: 4:30 PM dose administered at 5:39 PM, which is 3 hours and 23 minutes after the last dose was administered, as opposed to 4 hours apart-12/31: 5:00 AM dose administered at 7:59 AM- 12/31: 8:30 AM dose administered at 8:52 AM, 1 hour and 7 minutes after the last dose was administered, as opposed to 3 hours and 30 minutes apartReview of the MAR Administration Details for January 2026 revealed the following:- 1/1: 8:30 AM dose administered at 10:52 AM- 1/1: 12:30 PM dose administered at 12:41 PM, 1 hour and 49 minutes after the last dose was administered, as opposed to 4 hours apart- 1/1: 4:30 PM dose administered at 7:19 PM, 2 hours and 11 minutes after the scheduled time- 1/2: 5:00 AM dose administered at 7:02 AM, 2 hours late- 1/2: 8:30 AM dose administered at 11:03 AM, 2 hours and 33 minutes late- 1/2: 12:30 PM dose administered at 11:31 AM, 28 minutes after the last dose was administered, as opposed to 4 hours apart- 1/3: 5:00 AM dose administered at 9:14 AM, 4 hours and 14 minutes late- 1/3: 8:30 AM dose administered at 10:43 AM, 1 hour and 29 minutes after the last dose was administered, as opposed to 3 hours and 30 minutes apart- 1/3: 12:30 PM dose administered at 12:07 PM, 1 hour and 24 minutes after the last dose was administered, as opposed to 4 hours apart- 1/4: 8:30 AM dose administered at 10:48 AM, 2 hours and 18 minutes late- 1/4: 4:30 PM dose administered at 8:22 PM, 3 hours and 8 minutes late- 1/6: 12:30 PM dose administered at 2:16 PM, 1 hour and 46 minutes late- 1/7: 8:30 AM dose administered at 10:07 AM, 1 hour and 37 minutes late- 1/7: 12:30 PM dose administered at 2:27 PM, 1 hour and 53 minutes late- 1/7: 4:30 PM dose administered at 6:21 PM, 1 hour and 59 minutes late- 1/8: 4:30 PM dose (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered at 8:04 PM, 3 hours and 34 minutes late- 1/10: 8:30 AM dose administered at 10:06 AM, 1 hour and 36 minutes late- 1/10: 12:30 PM dose administered at 11:31 AM, 1 hour and 25 minutes after the last dose was administered, as opposed to 4 hours apart- 1/10: 4:30 PM dose administered at 9:53 PM, 5 hours and 23 minutes late- 1/11: 8:30 AM dose administered at 10:44 AM, 2 hours and 14 minutes late- 1/11: 12:30 PM dose administered at 11:43 AM, 59 minutes after the last dose was administered, as opposed to 4 hours apart- 1/11: 4:30 PM dose administered at 7:43 PM, 3 hours and 13 minutes apartDuring a surveyor interview on 1/15/2026 at 9:55 AM, with the DNS, she acknowledged Resident ID #17's Rytary was not administered per the physician's order and indicated that it should have been.3) Record review revealed Resident ID #208 was admitted to the facility in January of 2026 with a diagnosis including, but not limited to, altered mental status.Review of a progress note dated 1/11/2026, authored by an on-call provider, revealed nursing called and reported the resident was experiencing increased agitation, a runny nose, and weakness. Further review states in part, .Nursing staff to discuss with family/POA [Power of Attorney] regarding whether or not they would like the patient to be tested for COVID and FLU and will notify this [Nurse Practitioner] of their decision. If so, then the staff may test for COVID and FLU.Record review revealed a physician order, scanned into the resident's electronic medical record (EMR), dated 1/11/2026, which states in part, Please discuss with family/POA regarding whether or not they would like the patient to be tested for COVID and FLU and notify clinician of their decision. -If family/POA want patient to be tested for COVID and FLU, then you may test patient for COVID and FLU and notify a clinician of the results.Record review failed to reveal evidence that Resident ID #208's family/POA was contacted to discuss testing the resident for COVID or FLU.During a surveyor interview on 1/14/2026 at 9:54 AM, with LPN, Staff B, she revealed that she was unaware if the resident's family was contacted to discuss testing him/her for COVID/FLU and revealed that if the family was contacted, it should be documented in a progress note. Further, she was unable to provide evidence that Resident ID #208's family was contacted, per the physician's order.During a surveyor interview on 1/14/2026 at 11:18 AM, with Resident ID #208's family member, s/he revealed that the facility had not called him/her about testing the resident for COIVD or the FLU and indicated that had s/he been called and the resident was symptomatic, s/he would have approved the testing.During a surveyor interview on 1/14/2026 at 11:28 AM, with the DNS, she revealed that the on-call providers write their physician's orders in a progress note and in a document that is scanned to the facility. She revealed that it is the nurse's responsibility to ensure the physician's order is entered into the residents EMR. Further, she revealed that she would have expected staff to call the resident's family to discuss testing him/her and revealed that the notification should be documented in a progress note.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure that each resident's medication regimen is free from a medication error rate of 5% or greater. Based on 27 opportunities for errors observed during the medication administration task, there were 2 errors resulting in an error rate of 7.41%, involving Resident ID #s 56 and 161.Findings are as follows:Review of a facility policy titled, Administering Medications last revised in [DATE] states in part, Medications are administered in a safe and timely manner, and as prescribed.1.Record review for Resident ID #161 revealed a physician's order for ertapenem sodium (an antibiotic) and to infuse 500 milligrams every 24 hours intravenously at a rate of 105 milliliters per hour (ml/hr) for a urinary tract infection.During a surveyor observation of the medication administration task on [DATE] at approximately 1:10 PM with Registered Nurse, Staff D, she began infusing the resident's antibiotic but was asked by the surveyor to pause the infusion. An additional observation revealed the medication had expired on [DATE] and the flow rate was incorrectly set to 100 ml/hr instead of the prescribed flow rate of 105 ml/hr.During a surveyor interview immediately following the above observation with Staff D, she acknowledged the medication was expired and the flow rate was not set as prescribed.2.Record review for Resident ID #56 revealed a physician's order for Lactaid oral tablet and to administer one tablet before meals for lactose intolerance.During a surveyor observation of the medication administration task on [DATE] at approximately 8:55 AM with Certified Medication Technician, Staff G, she administered the Lactaid tablet to the resident.During a follow up surveyor interview on [DATE] at approximately 1:50 PM, she acknowledged administering the Lactaid tablet to the resident after s/he had already eaten his/her breakfast.During a surveyor interview on [DATE] at approximately 3:00 PM with the Director of Nursing Services, she revealed that medications are to be administered as prescribed. She was unable to provide evidence that the facility ensured each resident's medication regimen is free from a medication error rate of 5% or greater.