STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415085	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount St Rita Health Centre	15 Sumner Brown Road Cumberland, RI 02864

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 - Some	Ensure services provided by the nursing facility meet professional standards of quality. 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, for 1 of 1 resident reviewed with a standing physician's order for insulin with special instructions, Resident ID #9, and for 1 of 1 resident reviewed for off-loading heels, Resident ID #47.Findings are as follows:According to Mosby's 4th Edition, Fundamentals of Nursing page 314, 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.1. Record review revealed Resident ID #9 was re-admitted to the facility in June of 2025 with a diagnosis including, but not limited to, type two diabetes mellitus with hyperglycemia (high blood sugar).Review of a care plan focus area, last revised 9/22/2025, revealed that Resident ID #9 has diabetes mellitus and is insulin dependent. Interventions include, but are not limited to, administer diabetes medication as ordered by the physician and report any signs or symptoms of hyperglycemia.Record review revealed a physician's order dated 9/19/2025 for Humalog Injection Solution (insulin) 100 unit/milliliter, with instructions to administer 16 units subcutaneously (under the skin) before meals and to call the provider if his/her blood sugar is below 70 or above 350.Review of the November and December 2025 Medication Administration Records revealed on the following dates and times the resident's blood sugar was above 350:- 11/2 at 4:30 PM with a blood sugar of 411- 11/10 at 11:30 AM with a blood sugar of 357- 11/13 at 11:30 AM with a blood sugar of 383- 11/13 at 4:30 PM with a blood sugar of 390- 11/14 at 11:30 AM with a blood sugar of 362- 11/21 at 4:30 PM with a blood sugar of 387- 11/22 at 11:30 AM with a blood sugar of 373- 11/25 at 4:30 PM with a blood sugar of 368- 11/27 at 4:30 PM with a blood sugar of 392- 12/1 at 11:30 AM with a blood sugar of 351Record review of the progress notes failed to reveal evidence that the physician was notified for 7 out of the 10 opportunities in November and December, where his/her blood sugar was above 350: 11/10, 11/13 at 11:30 AM, 11/21, 11/22, 11/25, 11/27, and 12/1/2025.During a surveyor interview on 12/4/2025 at 8:56 AM, with Registered Nurse, Staff A, she acknowledged the blood sugar parameters associated with the resident's Humalog order and revealed that any provider notification should be documented in a progress note. Further, she was unable to provide evidence that the physician was notified for 7 out of 10 opportunities where Resident ID #9's blood sugar was above 350.During surveyor interviews on 12/4/2025 at 10:04 AM and 10:53 AM with the Director of Nursing Services (DNS), she revealed that she would have expected nursing to notify the resident's provider when his/her blood sugar was above the indicated parameter, and was unable to provide evidence that the physician was notified for 7 out of 10 opportunities where Resident ID #9's blood sugar was above 350.During a surveyor interview on 12/4/2025 at 11:30 AM, with the Nurse Practitioner, she revealed that she would expect staff to notify her when the resident's blood sugar is above or below the indicated parameters.2. Record review revealed Resident ID #47 was readmitted to the facility in October of 2024 with a diagnosis including, but not limited to, dementia.Record review revealed a physician's order dated 11/8/2024 to offload the resident's bilateral heels while in bed.During surveyor observations on the following dates and times, the resident was observed in bed, with his/her heels resting directly on the mattress, indicating they were not offloaded:- 12/1/2025 at 11:30 AM- 12/2/2025 at 9:49 AM- 12/3/2025 at 10:30 AMDuring a (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415085	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount St Rita Health Centre	15 Sumner Brown Road Cumberland, RI 02864

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 - Some	surveyor interview on 12/3/2025 at 10:42 AM, with Licensed Practical Nurse, Staff B, she acknowledged that Resident ID #47's heels were not offloaded and indicated that they should be.During a surveyor interview on 12/3/2025 at 12:32 PM, with the DNS, she revealed that she would expect Resident ID #47's bilateral heels to be offloaded while in bed, per the physician's order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415085	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount St Rita Health Centre	15 Sumner Brown Road Cumberland, RI 02864

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure that resident records are complete and accurately documented relative to 1 of 1 resident observed for wound care, Resident ID #11, and 1 of 1 resident reviewed for off-loading heels, Resident ID #47.Findings are as follows: 1. Record review revealed Resident ID #11 was readmitted to the facility in September of 2023, with a diagnosis including, but not limited to, stage IV pressure ulcer (the most severe pressure wound that may impact muscle, tendons, ligaments, and bone).Record review revealed the following physician's orders:-10/10/2025: Obtain wound measurements and document in a progress note-10/24/2025: Measure the coccyx (tailbone) wound and document in a progress note-11/7/2025: Measure the coccyx wound and document in a progress note-11/21/2025: Measure the coccyx woundReview of the October and November 2025 Treatment Administration Records (TAR) revealed that the above orders were all documented as completed by Licensed Practical Nurse, Staff B.Although, record review failed to reveal evidence that wound measurements were obtained and documented on 10/10, 10/24, 11/7 and 11/21/2025.During a surveyor interview on 12/3/2025 at approximately 10:50 AM, with Staff B, she acknowledged documenting the above orders as completed, but was unable to provide evidence that wound measurements were obtained, as ordered.2. Record review revealed Resident ID #47 was readmitted to the facility in October of 2024 with a diagnosis including, but not limited to, dementia.Record review revealed a physician's order dated 11/8/2024 to offload the resident's bilateral heels while in bed, every shift.During surveyor observations on the following dates and times, the resident was observed in bed, with his/her heels resting directly on the mattress, indicating they were not offloaded: - 12/1/2025 at 11:30 AM - 12/2/2025 at 9:49 AM - 12/3/2025 at 10:30 AMReview of the December 2025 TAR revealed that the above-mentioned order was documented as completed for all shifts on 12/1 and 12/2.During a surveyor interview on 12/3/2025 at 10:42 AM, with Staff B, she acknowledged that Resident ID #47's heels were not offloaded and indicated that they should be.During a surveyor interview on 12/3/2025 at 12:32 PM, with the Director of Nursing Services, she was unable to provide evidence that resident records are complete and accurately documented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415085	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount St Rita Health Centre	15 Sumner Brown Road Cumberland, RI 02864

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **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 a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent infection for 1 of 1 resident observed for wound care, Resident ID #11.Findings are as follows:1. Review of a facility policy titled, Clean Dressing Change states in part, .It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. Physician's orders will specify type of dressing.remove existing dressing.remove gloves.Wash hands and put on clean gloves.Record review revealed the resident was readmitted to the facility in September of 2023 with a diagnosis including, but not limited to, stage IV pressure ulcer (the most severe pressure wound that may impact muscle, tendons, ligaments, and bone).Review of a care plan focus area, dated 11/10/2020, revealed the resident has a coccyx (tailbone) wound with interventions that include to administer treatments, as ordered, and to measure and document weekly the width, length, depth, type of tissue, and drainage. Additionally, s/he is followed by a wound specialist.Review of a physician's order dated 1/31/2025 revealed, to cleanse his/her coccyx wound with Vashe (a wound cleanser), pat dry, apply skin prep (a skin protectant) to the peri wound, loosely pack calcium alginate with silver (a wound treatment) into the wound bed, and cover with a silicone border dressing daily and as needed.1a. During a surveyor observation of the resident's wound treatment on 12/2/2025 at approximately 1:30 PM, with Licensed Practical Nurse, Staff C, he was observed to have removed the soiled dressing and discarded it, then proceeded to cleanse the wound. Staff C then removed his gloves and discarded them, and donned new gloves, without first performing hand hygiene. Staff C then opened a sealed, sterile package of calcium alginate with silver and cut a circle from the sheet and placed it on top of the packaging, which was not sterile. Staff C then used the small circle of calcium alginate with silver, that was placed on top of the unsterile packaging, to pack the resident's wound. Staff C then completed the wound treatment by covering the wound with an island dressing instead of a silicone dressing, as ordered.During a surveyor interview immediately following the above observation with Staff C, he acknowledged that he did not perform hand hygiene between changing gloves and should have. Additionally, he acknowledged using an island dressing to cover the wound instead of a silicone dressing as ordered and revealed that he always uses the island dressing because the facility does not have the silicone dressing. Further, he could not recall placing the piece of sterile calcium alginate with silver on top of the unsterile packaging prior to packing the resident's wound.During a surveyor interview on 12/2/2025 at 2:08 PM, with the Wound Nurse, she revealed that she would expect Staff C to have performed hand hygiene between changing gloves and utilize the dressing that is ordered. Additionally, she revealed that the facility has silicone dressings specifically for Resident ID #11's wound.1b. Review of a facility policy titled, Documentation of Wound Treatments states in part, .Wound assessments are documented.weekly.The following elements are documented as part of a complete wound assessment.type of wound.stage of wound.Measurements: height, width, depth, undermining, tunneling.Description of wound characteristics.Color of the wound bed.type of tissue.condition of the peri- wound skin.presence, amount, and characteristics of wound drainage.Presence or absence of odor.Presence or absence of pain .Record review failed to reveal evidence of weekly wound measurements and descriptions of wound characteristics for 1 of 4 opportunities between 11/1 and 11/30/2025.Record review revealed a skin assessment dated [DATE] that revealed the resident has a coccyx wound, but the wound was documented as being Not Evaluated.During a subsequent surveyor interview on 12/2/2025 at 3:07 PM, with the Wound Nurse, she revealed that the resident's wound is evaluated weekly when the nurses complete the weekly skin assessment. Additionally, she acknowledged that the wound was not evaluated on 11/22/2025 and revealed it should have been.1c. According to Mosby's 4th Edition, Fundamentals of Nursing page (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415085	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount St Rita Health Centre	15 Sumner Brown Road Cumberland, RI 02864

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	314, 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.Review of the November 2025 Treatment Administration Record failed to reveal evidence that the resident's daily wound treatment was completed, as ordered, on 11/27/2025.During a surveyor interview on 12/3/2025 at approximately 12:30 PM, with the Director of Nursing Services, she revealed that she would expect the resident's wound to be evaluated weekly and wound treatments to be completed as ordered. Additionally, she revealed that she would expect staff to provide wound care consistent with professional standards of practice. Cross reference F 726

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415085	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount St Rita Health Centre	15 Sumner Brown Road Cumberland, RI 02864

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure that staff were competent to provide nursing and related services to assure resident safety to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident, as a nurse did not follow proper infection control practices or follow a physician's order during a resident's wound treatment and had not completed a facility provided competency for clean dressing changes, for 1 of 3 Licensed Practical Nurses (LPN) reviewed, LPN, Staff C. Findings are as follows:Review of the Facility Assessment last revised in November of 2025 revealed, that licensed nurses will receive education on topics that include, but are not limited to, skin care.Record review revealed LPN, Staff C, was hired on 9/9/2025.Further record review failed to reveal evidence that Staff C completed a clean dressing change competency. Record review revealed Resident ID #11 was readmitted to the facility in September of 2023 with a diagnosis including, but not limited to, stage IV pressure ulcer (the most severe pressure wound that may impact muscle, tendons, ligaments, and bone).Review of a physician's order dated 1/31/2025 revealed, to cleanse his/her coccyx wound with Vashe (a wound cleanser), pat dry, apply skin prep (a skin protectant) to the peri wound, loosely pack calcium alginate with silver (a wound treatment) into the wound bed, and cover with a silicone border dressing daily and as needed.During a surveyor observation of the resident's wound treatment on 12/2/2025 at approximately 1:30 PM, with Staff C, he was observed to have removed the soiled dressing, discarded it, and proceeded to cleanse the wound. Staff C then removed his gloves and discarded them, and donned new gloves, without first performing hand hygiene. Staff C then opened a sealed, sterile package of calcium alginate with silver and cut a circle from the sheet and placed it on top of the packaging, which was not sterile. Staff C then used the small circle of calcium alginate with silver, that was placed on top of the unsterile packaging, to pack the resident's wound. Staff C then completed the wound treatment by covering the wound with an island dressing instead of a silicone dressing, as ordered.During a surveyor interview immediately following the above observation with Staff C, he acknowledged that he did not perform hand hygiene between changing gloves and should have. Additionally, he acknowledged using an island dressing to cover the wound instead of a silicone dressing that was ordered and revealed that he always uses the island dressing because the facility does not have the silicone dressing. Further, he could not recall placing the piece of sterile calcium alginate with silver on top of the unsterile packaging prior to packing the resident's wound.During a surveyor interview on 12/2/2025 at 2:08 PM with the Wound Nurse, she revealed that she would have expected Staff C to have performed hand hygiene between changing his gloves and utilize the dressing that is ordered. Additionally, she revealed that the facility has silicone dressings specifically for Resident ID #11's wound.During a surveyor interview on 12/3/2025 at 12:10 PM, with the Staff Educator, she acknowledged that Staff C had not completed a clean dressing change competency and revealed that he should have completed it during the most recent education fair that was held in the fall of 2025, as he had attended the fair.During surveyor interviews on 12/3/2025 at 12:30 PM and 1:33 PM and 12/4/2025 at 10:53 AM, with the Director of Nursing Services, she revealed that she was unaware that Staff C had not completed a clean dressing change competency and revealed that he should have completed it during the annual education fair. She further revealed that licensed nurses should complete a clean dressing change competency during orientation but was unable to provide evidence that Staff C had completed the required competency during his orientation in September of 2025. Additionally, she revealed that she would expect staff to provide wound care consistent with professional standards of practice. Cross reference F 686

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415085	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount St Rita Health Centre	15 Sumner Brown Road Cumberland, RI 02864

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on surveyor observation, clinical record review, and staff interview, the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections, relative to staff wearing the appropriate personal protective equipment (PPE), for 1 of 1 resident observed on contact precautions (an infection control measure used in healthcare settings to prevent the spread of germs that can be transmitted by direct or indirect contact with a resident or their environment), Resident ID #18.Findings are as follows:Review of a facility policy titled, Transmission- Based Precautions dated 1/1/2025 to 12/31/2025, states in part, .General Guidelines: Perform hand hygiene upon entering and when exiting the room.Contact Precautions: Isolation gowns and gloves are required.Required personal protective equipment (PPE) should be donned before entering the room and disposed of before exiting the room.Diseases/microorganisms requiring Contact Precautions include but are not limited to.Conjunctivitis [pink eye] .Record review revealed Resident ID #18 was admitted to the facility in August of 2024 with a diagnosis including, but not limited to, conjunctivitis. Record review revealed a physician's order dated 11/24/2025 for contact precautions, every shift, due to a bacterial infection of the right eye.During a surveyor observation on 12/2/2025 at 11:10 AM revealed, the resident had signage posted at his/her doorway indicating that s/he was on contact precautions. Additionally, the signage indicated that staff are to wear a gown and gloves prior to entering the room.During a surveyor observation on 12/2/2025 at 11:14 AM, Nursing Assistant, Staff D, was observed entering the resident's room without wearing a gown and gloves, as indicated on the signage posted on the resident's door and the facility policy. Additionally, Staff D exited the room wearing soiled gloves and accessed the clean PPE bin to obtain a gown without performing hand hygiene.During a surveyor interview immediately following the above-mentioned observation with Staff D, she acknowledged that she did not wear a gown and gloves prior to entering the resident's room. Additionally, she was unaware why the resident was on precautions and stated, I'm not sure, maybe Covid. She further acknowledged the signage posted on the outside of the resident's door for contact precautions.During a surveyor interview on 12/2/2025 at 11:20 AM, with Registered Nurse, Staff E, she indicated that the resident is on contact precautions for conjunctivitis.During a surveyor interview on 12/3/2025 at approximately 10:03 AM, with the Infection Preventionist, she indicated that she would expect all staff to wear a gown and gloves each time they enter Resident ID #18's room. During a surveyor interview on 12/3/2025 at approximately 2:40 PM, with the Director of Nursing Services, she was unable to provide evidence the infection control precautions were followed by the staff, as required.