STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415087	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenville Operations RI LLC Dba Greenville Skille	735 Putnam Pike Greenville, RI 02828

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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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure a system was in place to prepare and serve food and fluids in a form designed to meet residents' prescribed dietary needs. Specifically, the facility failed to ensure nectar thick liquids (mildly thick fluid consistency required to promote safe swallowing) were prepared according to physician orders for 3 of 4 residents reviewed who were prescribed nectar thick liquids ,Resident ID #s 30, 17, and 39. This failure reflects a breakdown in the facility's system for implementing and monitoring prescribed diet modifications and placed residents at risk for choking, aspiration, and other serious complications related to swallowing impairment.Findings are as follows:Review of the undated facility policy titled Thickened Liquids Preparation and Administration states in part, .Residents requiring thickened liquids will receive beverages prepared to the correct consistency as recommended by the Speech Language Pathologist (SPL) or provider. Thickened liquids will be prepared using the facility-approved thickening agent according to the manufacturer's instructions to ensure safe swallowing and reduce the risk of aspiration.1.Record review revealed that Resident ID #30 was initially admitted to the facility in April of 2024 with diagnoses including, but not limited to, Cerebral Palsy and dysphagia (difficulty swallowing).Record review revealed the resident had a gastrostomy tube (GT- a tube surgically placed through the abdomen, directly into the stomach).Record review revealed an order dated 10/3/2025, for a regular diet with pureed texture and nectar thick liquids.Record review of a progress note dated 2/19/2026 at 2:33 PM, revealed that Resident ID #30 was sent to the hospital for an evaluation due to having a distended abdomen accompanied by pain.Review of an additional progress note dated 2/19/2026 at 10:59 PM, revealed the resident was admitted with a diagnosis including, but not limited to, pneumonia.Review of the hospital discharge document dated 2/24/2026 revealed the resident was discharged back to the facility with a diagnosis including, but not limited to, possible aspiration pneumonia (a bacterial infection in the lungs caused by inhaling something other than air, like food or liquid).Review of an After Hours Telehealth Consult authored by a provider dated 2/24/2026, revealed the resident was readmitted to the facility requiring temporary enteral feeding (GT feeding that delivers nutrition directly into the stomach), while awaiting a speech and dietary consultation.Record review revealed the resident was evaluated by the Speech Language Pathologist (SLP) on 2/25/2026. Further review revealed the SLP recommended mildly thick drinks and pureed foods.Record review revealed a physician's order dated 3/2/2026 for a regular diet with pureed texture and nectar thick liquids.During a surveyor observation on 3/4/2026 at 9:14 AM, Nursing Assistant (NA), Staff A, mixed one packet of Honey Consistency [liquids as thick as honey, thicker than nectar consistency] thickening powder into a small plastic cup of milk on Resident ID #30's tray.During a surveyor interview immediately following the above observation, Staff A indicated that he was unaware of Resident ID #30's liquid consistency order and acknowledged that the packet of thickener was for honey consistency and not nectar as ordered. Additionally, he stated, that's just what they gave me.Review of the Honey Consistency thickener packet failed to reveal evidence of instructions for use to obtain a nectar thick consistency. During a surveyor interview on 3/4/2026 at approximately 9:15 AM with Licensed (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
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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Practical Nurse (LPN), Staff B, she acknowledged that Resident ID #30 should receive nectar thick liquids as ordered. Additionally, she revealed honey thick packets were the only packets available in the facility. Additionally, she revealed thickener is delivered to the unit from the kitchen when packets are unavailable.2a. Record review revealed Resident ID #39 was admitted to the facility in April of 2024 with diagnoses including, but not limited to, dementia and dysphagia.Record review of a care plan dated 6/8/2025 revealed the resident is at risk for impaired swallowing with an intervention to provide liquids at the consistency as ordered.Record review revealed a physician's order dated 10/1/2025 for nectar thick liquids. During a surveyor observation of the preparation of Resident ID #39's meal tray on 3/3/2026 at 12:10 PM revealed NA, Staff A, mixing two heaping spoonfuls of a white powder from an unlabeled container into a small plastic cup of juice.During an interview immediately following the above observation, Staff A, revealed he was unaware of the fluid consistency that was ordered for the resident. After the surveyor informed Staff A that the resident required nectar thick liquids, he was unable to determine the appropriate amount of thickener to add to the fluid to achieve nectar thick consistency.During a surveyor interview on 3/3/2026 at 2:22 PM with Dietary Aide, Staff M, he indicated that the kitchen sends up thickener in an unlabeled plastic container without the manufacture's label or thickening instructions.During a surveyor observation at the time of the above interview, the thickener was stored in the kitchen, in a container without the manufactures label or instructions for its use.2b. During a surveyor observation of the preparation of Resident ID #39's meal tray on 3/4/2026 at 8:19 AM revealed NA, Staff A, mixing two heaping spoonful's of a white powder from an unlabeled container into a small plastic cup of juice and two heaping spoonfuls into a larger cup of coffee.During a surveyor interview immediately following the above observation, Staff A, acknowledged that he does not measure the amount of thickener that he adds to liquids. During a surveyor interview on 3/4/2026 at 8:33 AM, the Unit Manager, Staff E, was interviewed in the presence of the LPN, Staff B. Staff E acknowledged that the thickening agent currently being used on the unit was not labeled and did not contain instructions for proper use. She further stated that staff should be utilizing pre-measured thickener packets when preparing thickened liquids. At that time, Staff E brought packets labeled Honey Consistency thickener to the unit, although no residents were prescribed honey consistency liquids.3. Record review revealed Resident ID #17 was admitted to the facility in January of 2021 with diagnoses including, but not limited to, dementia and cognitive communication deficit.Record review revealed a physician's order dated 10/1/2025 for nectar thick liquids.During a surveyor observation of the preparation of Resident ID #17's tray on 3/4/2026 at 8:10 AM, NA, Staff F, mixed one heaping spoonful of white powder into a small 5-ounce plastic cup of milk and one spoonful of white powder into a larger 8-ounce coffee cup.During a surveyor interview immediately following the above observation with Staff F, when asked what was in the container of the white powder, she revealed that it was thickener that is brought from the kitchen. She acknowledged that the container was not labeled and without instructions for use. Additionally, she revealed that she was unaware of how much thickener to add to the liquid, or what the resident's liquid consistency order was.During a surveyor interview on 3/4/2026 at 8:13 AM with Registered Nurse, Staff C, she indicated that two to three scoops should be added to each drink for any resident that requires thickened liquids. Additionally, she acknowledged that there was not a label or instructions for use available for the thickener. During surveyor interviews on 3/4/2026 at 9:33 AM and at 11:25 AM with the Director of Nursing Services, she was unaware of how to achieve the appropriate consistency for nectar thick liquids. Additionally, she acknowledged that the staff had not been educated on how to properly thicken liquids.The facility's failure to ensure a safe and consistent system for the preparation of prescribed thickened liquids, including the use of labeled thickening agents, manufacturer instructions, and staff competency, resulted in staff preparing liquids without knowledge of the required consistency. This systemic breakdown placed residents with dysphagia at risk for aspiration, choking, aspiration pneumonia, and other serious complications that could result in serious injury, serious harm, serious impairment, or death.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, and staff and resident interviews, the facility failed to provide an ongoing activity program on the weekends to support residents in their choice of activities based on the comprehensive assessment, care plan, and preferences. This affected all residents in the facility specifically for 5 of 9 residents reviewed, Resident ID #s 7, 42, 49, 70, and 71. Findings are as follows:Review of a facility policy titled, Resident's/Patient's Choice dated 8/7/2023 states in part, Resident's/Patients have the right to participate or not participate in leisure and recreation of their choosing. To provide opportunities for leisure, recreation, and social involvement.Residents/Patients will be invited and encouraged to assist in the planning and development of recreation programming.Residents/Patients will be invited to attend activities of preference and interest and will be provided the opportunity to participate in structured and individual programs.During a surveyor interview on 3/4/2026 at approximately 1:00 PM with the members of Resident Council, the residents revealed that there are no activities offered on Saturdays and Sundays.Review of the Activities schedules for February and March 2026 revealed no activity staff were scheduled to work on Saturdays and Sundays.1. Record review revealed that Resident ID #7 was admitted to the facility in September of 2024 with a diagnosis including, but not limited to, anxiety.Review of a Comprehensive 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 of the MDS revealed that doing his/her favorite activities is very important.Review of a care plan dated 10/9/2024 revealed that Resident ID #7 states that it is important to have the opportunity to engage in daily routines that are meaningful relative to their preferences.2. Record review revealed that Resident ID #42 was admitted to the facility in July of 2023 with diagnoses including, but not limited to, anxiety and depression.Review of a Comprehensive MDS assessment dated [DATE] revealed a BIMS score of 13 out of 15 indicating intact cognition. Further review of the MDS revealed that doing his/her favorite activities is somewhat important.Review of a care plan dated 7/20/2023 revealed that Resident ID #42 states that it is important to have the opportunity to engage in daily routines that are meaningful relative to their preferences.3. Record review revealed that Resident ID #49 was admitted to the facility in December of 2022 with diagnoses including, but not limited to, anxiety and depression.Review of a Comprehensive MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15 indicating intact cognition. Further review of the MDS revealed that doing his/her favorite activities is somewhat important.Review of a care plan dated 8/7/2025 revealed that Resident ID #49 states that it is important to have the opportunity to engage in daily routines that are meaningful relative to their preferences.4. Record review revealed that Resident ID #70 was admitted to the facility in July of 2024 with diagnoses including, but not limited to, depression and anxiety.Review of a Comprehensive MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15 indicating intact cognition. Further review of the MDS revealed that doing his/her favorite activities is very important.Review of a care plan dated 7/29/2025 revealed that Resident ID #70 states that it is important to have the opportunity to engage in daily routines that are meaningful relative to their preferences.5. Record review revealed that Resident ID #71 was admitted to the facility in March of 2024 with diagnoses including, but not limited to, adjustment disorder and dementia.Review of a Comprehensive MDS assessment dated [DATE] revealed a BIMS score of 9 out of 15 indicating moderately impaired cognition. Further review of the MDS revealed that doing his/her favorite activities is somewhat important.Review of a care plan dated 7/29/2025 revealed that Resident ID #70 states that s/he enjoys leisure activities including coffee social, card playing, games of chance and bingo.During a surveyor interview on 3/5/2026 at 10:14 AM with the Administrator she acknowledged that they do not have activities staff scheduled and that none of the residents are offered structured activities on the weekends.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on clinical record review and staff interview, the facility failed to implement all required components of the facility-wide assessment and failed to annually review the facility's policies and procedures. Findings are as follows:Review of the Facility Assessment dated 1/5/2026 states in part, .Policies and Procedures: Review existing policies and procedures to ensure they meet current professional standards of practice and regulatory requirements. Identify any gaps or areas requiring updates based on evaluation findings.Record review failed to reveal evidence of annual reviews of the policies and procedures.Record review failed to reveal evidence that the facility assessment addressed the following:-any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities, and food and nutrition services.-contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during normal operations and emergencies.-health information technology resources such as systems for electronically managing patient records and electronically sharing information with other organizations.-maintain a plan to maximize recruitment and retention of direct care staff.During a surveyor interview on 3/5/2026 at 12:02 PM with the Administrator she was unable to provide evidence that the facility reviews all of their policies and procedures annually.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 clinical record review and staff interview, the facility failed to ensure that nursing staff have the appropriate competencies and skill sets 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 determined by resident assessments, and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment as required for 5 of 5 nursing staff reviewed related to appropriately thickening liquids, Staff A, B, C and F, and the Director of Nursing Services (DNS). Additionally, 3 of 5 staff members failed to follow and explain the difference between contact and enhanced barrier precautions (EBP), Staff E, G, and H; and the facility failed to provide competencies for 3 of 10 staff reviewed related to EBP and contact precautions, Staff H, I, and J.Findings are as follows:Record review of the Facility Assessment Template dated 1/5/2026 revealed that staff training and competencies are necessary to provide the level and types of support and care needed for the resident population.1a. Record review revealed a physician's order for Resident ID #30 dated 10/3/2025 for a regular diet with pureed texture and nectar thick liquids (mildly thick liquid consistency to assist with safe swallowing).During a surveyor observation on 3/4/2026 at 9:14 AM, Nursing Assistant (NA), Staff A, mixed one packet of Honey Consistency [liquids as thick as honey, thicker than nectar consistency] thickening powder into a small plastic cup of milk on Resident ID #30's tray.During a surveyor interview immediately following the above observation, Staff A indicated that he was unaware of Resident ID #30's liquid consistency order and acknowledged that the packet of thickener was for honey consistency and not nectar as ordered. Additionally, he stated, that's just what they gave me.During a surveyor interview on 3/4/2026 at approximately 9:15 AM with Licensed Practical Nurse (LPN), Staff B, she acknowledged that Resident ID #30 should receive nectar thick liquids as ordered. Additionally, she revealed honey thick packets were the only packets available. 1b. Record review revealed Resident ID #39 has a physician's order dated 10/1/2025 for nectar thick liquids. During a surveyor observation of the preparation of Resident ID #39's meal tray on 3/3/2026 at 12:10 PM revealed NA, Staff A, mixing two heaping spoonfuls of a white powder from an unlabeled container into a small plastic cup of juice.During an interview immediately following the above observation, Staff A, revealed he was unaware of the fluid consistency that was ordered for the resident. After the surveyor informed Staff A that the resident required nectar thick liquids, he was unable to determine the appropriate amount of thickener to add to the fluid to achieve nectar thick consistency.1c. Record review revealed Resident ID #17 had a physician's order dated 10/1/2025 for nectar thick liquids.During a surveyor observation of the preparation of Resident ID #17's tray on 3/4/2026 at 8:10 AM, NA, Staff F, mixed one heaping spoonful of white powder into a small 5-ounce plastic cup of milk and one spoonful of white powder into a larger 8-ounce coffee cup.During a surveyor interview immediately following the above observation with Staff F, when asked what was in the container of the white powder, she revealed that it was thickener that was sent up from the kitchen. She acknowledged that the container was not labeled and without instructions for use. Additionally, she revealed that she was unaware of how much thickener to add to the liquid, or what the resident's liquid consistency order was.During a surveyor interview on 3/4/2026 at 8:13 AM with Registered Nurse, Staff C, she indicated that two to three scoops should be added to each drink for any resident that requires thickened liquids. Additionally, she acknowledged that there was not a label or instructions for use available for the thickener. During surveyor interviews on 3/4/2026 at 9:33 AM and at 11:25 AM with the DNS, she was unaware of how to achieve the appropriate consistency for nectar thick liquids. Additionally, she acknowledged that the staff had not been educated on how to properly thicken liquids. Furthermore, she could not provide evidence of staff education or competencies related to appropriately thickening liquids.2. Record review of the facility provided document titled Infection (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Control Nursing Principles and Practices, dated 2016 states in part, .Contact precautions for organisms that are transmitted by direct or indirect contact with the patient or patient's environment. Requires gown & gloves before entering patient's room.Record review of the Centers for Disease Control and Prevention sign related to EBP stating, Providers and staff must also: Wear gloves and a gown [PPE - Personal Protective Equipment] for the following High-Contact Resident Care Activities.During a surveyor observation on 3/2/2026 at 9:35 AM, Resident ID #79 was noted to have a contact precaution sign posted outside his/her room. NA Staff G was observed going in the room and assisted the resident with his/her meal without wearing a gown and gloves before entering the room, as required.During a surveyor interview with Staff G following the above observation, she revealed that she was only told to wear PPE when providing care and not for anything else. Additionally, she acknowledged that the sign stated that Resident ID #79 was on contact precautions and was unable to explain the difference between contact precautions and EBP.During a surveyor observation on 3/3/2026 at 12:27 PM revealed NA, Staff H, entering Resident ID #79's room without a gown and gloves.During a surveyor interview with Staff H following the above observation, she acknowledged that she did not wear a gown or gloves prior to entering Resident ID #79's room and revealed that she was unaware of the difference between EBP and contact precautions.During a surveyor interview on 3/3/2026 at 12:31 PM with the Unit Manager, Staff E, she was unable to accurately describe the difference between contact precautions and EBP. She stated that universal precautions (standard precautions) were the same as EBP. Additionally, she added that a resident on contact precaution only requires wearing PPE when providing care, changing a wound dressing, or administering an intravenous medication.During a surveyor interview on 3/3/2026 at 2:28 PM with the DNS, she revealed that she would expect all staff to follow the precaution signs for each resident and to know the difference between EBP, contact, and standard precautions.3. Record review of the Facility Assessment Template dated 1/5/2026 revealed that staff competencies must be completed upon hire and annually.Record review failed to reveal evidence that Staff H, I, and J, received their annual trainings for EBP and contact precaution practices, as required.During a surveyor interview on 3/5/2026 at 12:50 PM with the DNS, she was unable to provide evidence that the Staff H, I, and J, received their annual trainings related to EBP and contact precautions within the last year, as required.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **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 accommodate the residents' food preferences for 4 of 4 residents reviewed who verbalized concerns regarding their food preferences, Resident ID #s 11, 13, 31, and 65.Findings are as follows:Record review of the facility policy titled, Resident Rights Under Federal Law last reviewed on 6/12/2025 states in part, .The resident has the right to make choices about aspects of his/her life in the facility that are significant to the resident. 1. Record review revealed Resident ID #11 was admitted to the facility in July of 2025 with a diagnosis including, but not limited to, anemia.Record review of Resident ID #11's Comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 indicating moderately impaired cognition.During a surveyor interview on 3/2/2026 at 12:42 PM with Resident ID #11, s/he revealed that the facility does not follow his/her diet preferences indicating that the diet slips do not match the food being served.During a surveyor observation following the above interview revealed the resident was served a pork chop, mashed potatoes, and cake.Record review of his/her diet slip revealed that s/he was supposed to receive parslied noodles and pudding. 2. Record review revealed Resident ID #13 was admitted to the facility in December of 2025 with a diagnosis including, but not limited to, heart failure.Record review of Resident ID #13's Comprehensive MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, indicating intact cognition.During a surveyor interview on 3/2/2026 at 12:40 PM with Resident ID #13, s/he revealed that the facility serves incorrect meals all the time. S/he revealed that despite selecting his/her preferences and reporting the discrepancies to dietary staff, s/he consistently receives items that do not match his/her meal ticket.During a surveyor observation following the above interview revealed that the resident was served mashed potatoes and vanilla cake.Record review of his/her diet slip revealed that s/he was supposed to receive mashed sweet potato and chocolate covered pumpkin cake.Further observation of breakfast on 3/5/2026 at approximately 8:30 AM revealed that the resident received scrambled eggs and toast.Record review of his/her diet slip revealed that s/he was supposed to receive sliced bread, egg whites, and an egg sandwich. 3. Record review revealed Resident ID #31 was admitted to the facility in October of 2023 with a diagnosis including, but not limited to, type 2 diabetes mellitus.Record review of Resident ID #31's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, indicating intact cognition.During a surveyor interview on 3/2/2026 at 12:40 PM with Resident ID #31, s/he revealed that the facility serves incorrect meals all the time. S/he revealed that despite selecting his/her preferences and reporting the discrepancies to dietary staff, s/he consistently receives items that do not match his/her meal ticket.Surveyor observation of the resident's meal following the above interview s/he received chicken, french fries, and cakeRecord review of his/her diet slip revealed that s/he was supposed to receive a baked pork chop, baked sweet potato wedges, and pumpkin pie.Further observation of breakfast on 3/5/2026 at 9:00 AM revealed that s/he received french toast and failed to have egg whites.Record review of his/her diet slip revealed that s/he was supposed to receive regular toast and egg whites.During a surveyor interview with the Nursing Assistant, Staff H, following the above observation, she acknowledged that Resident ID #31 was not served the menu items listed on the diet slip that s/he had requested to receive for breakfast. 4. Record review revealed Resident ID #65 was admitted to the facility in December of 2025 with a diagnosis including, but not limited to, anemia.Record review of Resident ID #65's Quarterly MDS assessment dated [DATE] revealed s/he has a BIMS score of 15 out of 15, indicating intact cognition.During a surveyor interview with Resident ID #65 on 3/3/2026 at 12:34 PM, s/he revealed that the facility serves incorrect meals and at times, not enough nutrition. S/he revealed that despite selecting his/her preferences and reporting the discrepancies to dietary staff, (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	s/he consistently receives items that do not match his/her diet slip.During a surveyor observation of Resident ID #65's meal following the above interview revealed s/he received vanilla puddingRecord review of his/her diet slip revealed that s/he was supposed to receive chocolate pudding.During a surveyor interview on 3/5/2026 at 10:11 AM with the Regional Food Service Manager, he acknowledged that the diet slip should match what is being served for all meals. Additionally, he would expect the staff to notify the residents when there are changes prior to the meals being served.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on surveyor observation, clinical record review, staff and resident interview, the facility failed to ensure residents are free from neglect relative to providing meals for 1 of 1 resident reviewed who had a recent diet order change, Resident ID #30.Findings are as follows:Review of the facility policy titled Abuse Prohibition last revised on 10/24/2022 states in part, .prohibit.neglect.for all patients.Neglect is defined as the failure.or disregard of the Center, its employees, or service providers to provide care, comfort, safety, goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. This includes the failure to implement an effective communication system across all shifts for communicating necessary care and information.Review of the undated facility policy titled Transmission of Diet Orders states in part, .Nursing staff will send the diet order to the food and nutrition services department as soon as possible after admission or diet change (preferably within 1 to 2 hours) .Record review revealed that Resident ID #30 was initially admitted to the facility in April of 2024 with diagnoses including, but not limited to, Cerebral Palsy and dysphagia (difficulty swallowing).Record review of a progress note dated 2/19/2026 revealed the resident was sent to the hospital for an evaluation and admitted with a diagnosis including, but not limited to, pneumonia.Review of an After Hours Telehealth Consult authored by a provider dated 2/24/2026 revealed the resident was readmitted to the facility requiring temporary enteral feeding (gastrostomy tube- a feeding that delivers nutrition directly into the stomach) while awaiting a speech and dietary consultation.Record review revealed the resident was evaluated by the Speech Language Pathologist (SLP) on 2/25/2026. Further review revealed the SLP recommended mildly thick drinks and pureed foods.Record review revealed a physician's order dated 3/2/2026 for a regular diet with pureed texture and nectar thick liquids (mildly thick liquids).During a surveyor observation on 3/3/2026 at approximately 12:30 PM, Resident ID #30 did not have a lunch tray brought to the unit.During a surveyor interview on 3/3/2026 at 12:34 PM with the resident, s/he indicated that s/he hadn't eaten dinner yesterday or breakfast or lunch that day. The resident further indicated that s/he was hungry.During a surveyor interview on 3/3/2026 at 12:43 PM with Nursing Assistant, Staff A, he revealed that the resident did not get a breakfast tray that morning and was not fed breakfast or lunch that day.During surveyor interviews on 3/3/2026 at 12:38 PM and at 12:47 PM with Licensed Practical Nurse (LPN), Staff B, she indicated that the resident was upgraded from a tube feeding to a pureed texture diet yesterday afternoon, on 3/2/2026. She further indicated that a diet order communication form had not been sent down to the kitchen, so kitchen staff were unaware that the resident needed a tray. Review of the Diet Order & Communication Form revealed it wasn't completed until 3/3/2026 at 12:30 PM by LPN, Staff B, after it was brought to her attention by the surveyor. Further review revealed the slip was for a Diet Order Change to pureed texture and nectar thick liquids.During a surveyor interview on 3/3/2026 at 2:12 PM with the Food Service Director, he revealed that diet orders are not changed with the kitchen until the kitchen receives the Diet Order & Communication Form from nursing. Additionally, he revealed that Resident ID #30 did not receive meals from the kitchen prior to receiving the communication form on 3/3/2026 at approximately 12:30 PM, after lunch had been delivered to the unit. He further revealed that the first tray that had been delivered from the kitchen recently was the late lunch tray on 3/3/2026.During a surveyor interview on 3/3/2026 at 2:43 PM with the Director of Nursing Services, she revealed that she had confirmed the new diet order with the provider on 3/2/2026 and did not complete the communication form for the new diet order to be sent to the kitchen. She further revealed that the dietitian usually gives the diet slips to the kitchen, however the dietitian did not complete the form for Resident ID #30 on 3/2/2026.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenville Operations RI LLC Dba Greenville Skille	735 Putnam Pike Greenville, RI 02828

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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 and staff interview, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, relative to physician's orders for 1 of 2 resident's reviewed for pressure ulcers, Resident ID #10.Findings are as follows:According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states in part, The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe that the orders are in error or would harm the clients.Record review revealed that the resident was admitted to the facility in April of 2020 with diagnoses including, but not limited to, dementia and multiple sclerosis (a disease that causes breakdown of the protective covering of nerves. causing numbness, weakness, trouble walking, vision changes and other symptoms).Record review revealed a physician's order for weekly skin assessments to be completed every Monday.Review of care plan dated 9/22/2024 revealed that the resident is at risk for pressure injury and skin breakdown related to incontinence and decreased mobility with interventions including, but not limited to, complete a weekly skin assessment by a licensed nurse.Record review failed to reveal evidence of completed skin assessments for 2/9, 2/16, 2/23, and 3/2/2026. Additionally, a skin assessment was not completed until 3/4/2026, after it was brought to the facility's attention by the surveyor.During a surveyor interview on 3/4/2026 at 11:16 AM with Registered Nurse, Staff C, she acknowledged that the last skin assessment was completed on 2/2/2026.During a surveyor interview on 3/4/2026 at 11:40 AM with the Director of Nursing Services she was unable to provide evidence that the facility completed the skin assessments as ordered.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure the residents receive treatment and care in accordance with professional standards of practice related to a wound vacuum device system (wound vac - a medical-grade suction system used for negative pressure wound therapy to accelerate the healing of chronic or acute, complex wounds) for 1 of 1 resident reviewed, Resident ID #79.Findings are as follows:Record review of the policy last reviewed on 5/1/2025 titled Skin Integrity and Wound Management states in part, .For surgical wounds.incisions.follow specific orders from surgeon.Record review revealed the resident was admitted in February of 2026 with a diagnosis including, but not limited, open wound of right back wall of thorax (area between the neck and the abdomen) with penetration into the thoracic cavity.Record review of the document titled Continuity of Care dated 2/27/2026 revealed an orthopedic spine surgery discharge instruction to continue with wound vac therapy. Further review revealed a setting recommendation of 125 mmHg (millimeters of mercury) negative pressure.Record review of a progress note dated 2/27/2026 revealed that the wound vac was discontinued and was changed to a daily dressing.Record review of a progress note dated 3/1/2026 at 6:50 PM revealed that the surgeon was notified of the change and gave a new recommendation to apply the wound vac to resident's back incision with 75 mmHg negative pressure continuously.Record review failed to reveal evidence that this new surgeon's recommendation to place the resident back on a wound vac at 75 mmHg negative pressure was reported to the physician.Record review of the Integrated Wound Care note dated 3/2/2026 revealed the resident has a mid/lower back surgical site with instructions to apply the wound vac per the surgeon's recommendations which was 75 mmHg.Surveyor observations revealed the resident's wound vac setting was at 125 mmHg instead of the surgeon's recommendation of 75 mmHg on the following dates and times:-3/3/2026 at 12:25 PM and 1:22 PM-3/4/2026 at approximately 9:00 AMDuring a surveyor interview on 3/3/2026 at 2:16 PM with Unit Manager, Staff E, she revealed that she was unaware that the resident's wound vac is supposed to be set at 75 mmHg negative pressure and acknowledged that it was set at 125 mmHg negative pressure.During a surveyor interview on 3/4/2026 at 3:04 PM with the Wound Nurse, she revealed that she was unaware of the surgeon's change of recommendation for the wound vac's negative pressure from 125 mmHg to 75 mmHg.During a surveyor interview on 3/4/2026 at 9:45 AM with the surgeon's office secretary, she acknowledged that the surgeon recommended applying the wound vac to his/her back incision with 75 mmHg negative pressure continuously.Record review of a nursing progress note dated 3/4/2026 at 8:37 PM revealed that the wound vac's setting was changed to 75 mmHg per the surgeon's recommendation, after it was brought to their attention to the surveyor.During a surveyor interview on 3/5/2026 at 9:59 AM with the Director of Nursing Services, she was unable to provide evidence that the surgeon's recommendation for the wound vac setting was reported to the provider and was followed per the facility policy.During a surveyor interview on 3/5/2026 at 11:48 AM with the Medical Director, he revealed that he would expect the staff to notify him of the surgeon's recommendations timely and to follow the surgeon's recommendations of applying the wound vac continuously at 75 mmHg.

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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. Based on 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, prevent infection and prevent new ulcers from developing relative to weekly wound documentation and having a wound treatment in place for 1 of 1 resident observed with a stage 3 pressure ulcer (deep, open wound exposing the subcutaneous tissue caused by pressure on the skin for an extended period time), Resident ID #10. Findings are as follows:Review of a facility policy titled, Skin Integrity and Wound Management dated 5/1/2025 states in part, .provide safe and effective care to promote optimal skin health, prevent pressure injuries, and promote healing.perform daily monitoring of wounds or dressings for presence of complications or declines. Document daily monitoring of ulcer/wound site with or without dressing. Monitor: Status of dressing.Status of the tissue surrounding the dressing.Signs of decline in the wound status.According to Pearson's Nursing A Concept-Based Approach to Learning, third edition 2019, which states in part, .Pressure injuries with full-thickness tissue loss (stages 3 and 4 .) .Clinical Therapies .dressings that maintain moisture are typically used .these dressings protect the wound from friction and bacterial colonization .Record review revealed that the resident was admitted to the facility in April of 2020 with diagnoses including, but not limited to, dementia and multiple sclerosis (a disease that causes breakdown of the protective covering of nerves. causing numbness, weakness, trouble walking, vision changes and other symptoms).A. Review of a care plan dated 9/22/2024, revealed the resident is at risk for skin breakdown due to incontinence and decreased mobility with an intervention including, but not limited to, provide wound treatment as ordered.Review of a Skin and Wound Evaluation dated 2/4/2026 revealed the resident has a new facility acquired, Stage III pressure ulcer (a serious skin injury characterized by full-thickness skin loss, exposing subcutaneous fat) to his/her left buttock, measuring 3.2 centimeters (cm) by 1.9 cm.Record review revealed the following physician's orders:-apply medi-honey (a wound treatment) and cover with a dry clean dressing daily with a start date of 2/5/2026 and an end date of 2/10/2026.-apply calcium alginate (a wound treatment) and cover with a bordered gauze with a start date of 2/17/2026.Record review failed to reveal evidence of a treatment order from 2/10/2026 until 2/17/2026.Record review failed to reveal evidence that wound care and daily monitoring of the wound were completed from 2/10/2026 until 2/17/2026.During a surveyor interview on 3/4/2026 at 11:16 AM with Registered Nurse (RN), Staff C acknowledged that there was not a wound treatment in place for Resident ID #10 from 2/10/2026 through 2/17/2026. During a surveyor interview on 3/12/2026 at 12:49 PM with the Medical Director, he revealed that he would expect a resident with a Stage III pressure ulcer to have a treatment in place. Additionally, he revealed that he was unaware that the resident did not have a treatment order in place for 7 days. B. Review of the care plan revealed an intervention dated 11/3/2025 to complete a weekly wound assessment including measurements and a description of the wound status.Record review failed to reveal evidence of wound measurements and a description of the wound for the following weeks:-2/8-2/14/2026-2/22-2/28/2026During a surveyor interview on 3/4/2026 at 11:16 AM with Staff C, she acknowledged that there were no wound measurements or a description of the wound for the above noted dates per the facility policy and the care plan.During a surveyor interview on 3/4/2026 at 11:40 AM with the Director of Nursing Services, she was unable to provide evidence that the facility provided wound care consistent with professional standards for Resident ID #10.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on surveyor observation, clinical record review, and staff interview, the facility failed to provide respiratory care consistent with professional standards of practice for 2 of 4 residents reviewed for oxygen use, Resident ID #s 9 and 80.Findings are as follows:According to Lippincott Nursing Procedure Ninth Edition 2023, page 621, states in part, .Verify the practitioner's order for oxygen therapy, because oxygen is considered a medication or therapy and should be prescribed .1. Record review revealed Resident ID #9 was admitted to the facility in July 2023 with diagnoses including, but not limited to, congestive heart failure (when the heart muscle is too weak or stiff to pump blood efficiently, causing blood and fluids to back up into the lungs, liver, or legs), and dementia.During surveyor observations on the following dates and times, Resident ID #9 was observed receiving 2 liters (L) of oxygen via nasal cannula: -3/3/2026 at 8:45 AM -3/4/2026 at 8:00 AM -3/5/2026 at 8:15 AMRecord review failed to reveal evidence of a physician's order for the use of oxygen, as required. During a surveyor observation on 3/5/2026 at approximately 10:30 AM, in the presence of Licensed Practical Nurse (LPN), Staff D, Resident ID #9 was observed in bed receiving oxygen via nasal cannula.During a surveyor interview on 3/5/2026 at 10:42 AM with the LPN, Staff D, she acknowledged that the resident was receiving oxygen and did not have a physician's order. 2. Record review revealed Resident ID #80 was admitted to the facility in January of 2026 with diagnoses including, but not limited to, respiratory failure, and anxiety.During surveyor observations on the following dates and times, Resident ID #80 was observed receiving 2 L of oxygen via nasal cannula: -3/2/2026 at 9:14 AM -3/2/2026 at 12:30 PM -3/3/2026 at 7:55 AM-3/3/2026 at11:20 AM Record review failed to reveal evidence of a physician's order for the use of oxygen, as required. Additionally, Resident ID #80 did not have cautionary, or safety signage posted on the room door indicating the use of oxygen. During a surveyor interview on 3/3/2026 at 2:16 PM with the Unit Manager, Staff E, she acknowledged that Resident ID #80 was receiving oxygen and did not have a physician's order. During a surveyor interview on 3/3/2026 at 2:28 PM with the DNS, she acknowledged that the resident was being receiving oxygen and did not have a physician's order.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on clinical record review and staff interview, the facility failed to ensure that residents who require dialysis (a treatment that removes excess fluid, waste, and toxins from the blood when the kidneys are no longer functioning properly) receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 2 residents reviewed for fluid management related to dialysis, Resident ID #11.Findings are as follows:Review of a facility policy titled Nutrition/Hydration Care and Services last reviewed 2/1/2023 states in part, .When a physician.orders a fluid restriction due to a specific clinical condition.dietary will calculate the amount of fluids to be provided on the meal trays.nursing will calculate the remaining amounts of fluids allotted for each shift.monitor intake and output.a. Record review revealed the resident was admitted to the facility in July of 2025, with a diagnosis including, but not limited to, end stage renal disease (ESRD).Record review revealed Resident ID #11 receives dialysis three times a week.Record review revealed a physician's order with a start date of 1/12/2026 for a 1200 milliliter (mL) fluid restriction per day to monitor each shift and for 11 PM to 7 AM shift to total the amount for 24 hours.Review of a care plan dated 8/2/2025 revealed Resident ID #11 is at nutritional risk related to ESRD and is dependent on dialysis with a fluid restriction of 1200 mL with an intervention to monitor intake.Review of the February and March 2026 Medication Administration Record (MAR) revealed the intake was not being totaled every 24 hours as ordered.Record review of written documents titled Dialysis Fluid Restriction revealed they dd not equal the amount documented on the MAR for 28 of 28 opportunities in the month of February.Record review failed to reveal evidence that Resident ID #11's fluid intake was being consistently and accurately monitored.b. Record review of the February 2026 MAR revealed the intake amounts documented were over the 1,200 fluid restriction on the following dates:-2/3- 1,320 mL-2/17- 1,320 mL-2/20- 2,080 mL-2/21- 2,160 mL -2/22- 1,320 mL -2/26- 1,320 mL-2/27- 1,240 mLRecord review failed to reveal evidence that a provider was notified that the resident's intake was over the ordered fluid restriction on the above dates.During a surveyor interview on 3/3/2026 at 12:47 PM with Licensed Practical Nurse, Staff B, she acknowledged that the written intake documentation and the documentation on the MAR were inconsistent and should not be. Additionally, she could not explain the amount of fluids that the resident actually drank and indicated that she writes what the intake is supposed to be. During a surveyor interview on 3/5/2026 at 10:54 AM with the Director of Nursing Services, she indicated that she would expect fluid intakes to be accurately documented and the written fluid intake documentation to match the documentation in the MAR.During a surveyor interview on 3/5/2026 at 11:48 AM with the Medical Director, he indicated that he would expect a resident's fluid intake to be accurately documented and monitored if there is a physician's order for a fluid restriction. Additionally, he revealed that he would expect that a provider would be notified if the resident's intake is over the ordered fluid restriction.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 clinical record review and staff interview, the facility failed to address pharmacy recommendations in a timely manner for 2 of 5 residents reviewed for the January pharmacy recommendations, Resident ID #s 11 and 52. Findings are as follows:Review of a facility policy titled, Medication Regimen Review and Reporting dated 1/2024 states in part, .The consultant pharmacist reviews the medication regimen and medical chart of each resident at least monthly.The nursing care center follows up on the recommendations to verify that appropriate action has been taken. Recommendations should be acted upon within 30 calendar days or per facility specific protocols.1. Record review revealed that Resident ID #11 was admitted to the facility in July of 2025 with diagnoses including, but not limited to, post-traumatic stress disorder and anxiety.Review of a Note to Attending Physician/Prescriber dated 1/27/2026, authored by the facility's contracted pharmacy, revealed a recommendation for Resident ID #30 to, .Please consider a trial dose reduction: trazadone 75 mg [milligram] HS [hour of sleep], Quetiapine 75 mg QAM [every morning], Sertraline 150 mg QD [every day].Further review failed to reveal evidence that the facility addressed the above pharmacy recommendation within 30 days per the policy.Review of a Note to Attending Physician/Prescriber dated 2/25/2026, authored by the facility's contracted pharmacy, revealed a recommendation for Resident ID #30 to, Please consider a trial dose reduction: trazadone 75 mg HS, Quetiapine 75 mg QAM, Sertraline 150 mg QD.Further review revealed documentation indicating that the Medical Director agreed with a dose reduction for Trazadone 75 mg and no change for the other medications. This document was undated and the dose reduction for the trazadone was started on 3/5/2026, after the surveyor brought this to the facility's attention. 2. Record review revealed that Resident ID #52 was admitted to the facility in November of 2024 with diagnoses including, but not limited to, Parkinson's and schizophrenia.Review of a Nursing Recommendations/Nurse Manager Report dated 1/30/2026 states in part, .Please update Lasix 100mg QD order to reflect how pharmacy is sending. Please change to 80 mg + 20 mg tablet to be given together to equal 100 mg dose.Record review failed to reveal evidence that the above recommendation was acted on within 30 days per the policy.During a surveyor interview on 3/5/2026 at 2:25 PM with the Director of Nursing Services she was unable to provide evidence that the pharmacy recommendations for January 2026 were acted on within 30 days per the facility policy.

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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 any significant medication error, for 1 of 1 resident reviewed related to warfarin therapy (a medication prescribed to reduce the blood's ability to clot, preventing or treating blood clots), Resident ID #13.Findings are as follows:Review of a document titled, A Guide to Taking Warfarin created by the American Heart Association, states in part, .It's important to monitor the INR [International Normalized Ratio, a standardized way to measure the prothrombin time [PT] of a blood sample. The INR is used to monitor the effectiveness of Warfarin] at least once a month and sometimes as often as twice weekly to make sure the level of warfarin remains effective. If the INR is too low, blood clots will not be prevented, but if the INR is too high, there is an increased risk of bleeding .Record review revealed the resident was admitted to the facility in December of 2025 with diagnoses including, but not limited to, atrial fibrillation (an irregular heartbeat) and heart failure (a chronic, progressive condition where the heart muscle cannot pump enough blood to meet the body's needs, often causing fluid buildup in the heart, lungs and legs).Record review revealed a physician's order to obtain a PT/INR laboratory test on 2/25/2026.The PT/INR was completed on 2/25/2026 but the results were not communicated to the physician until 2/26/2026. This delay in reporting the Pt/INR resulted in the resident missing one dose of Warfarin on 2/25/2026.Further record review of a progress note dated 2/26/2026 revealed a physician's order to obtain the PT/INR on Monday, 3/2/2026.Record review failed to reveal evidence that the PT/INR was obtained on 3/2/2026 as ordered.During a surveyor interview on 3/3/2026 at 2:16 PM with the Unit Manager, Staff E, she acknowledged that the resident missed his/her warfarin dose on 2/25/2026 and that the PT/INR result was not reported to the physician until 2/26/2026. Additionally, she acknowledged that the PT/INR should've been obtained on 3/2/2026 per the physician's order.During a surveyor interview with the Medical Director on 3/5/2026 at 11:48 AM, he indicated that he would expect the PT/INR to be obtained and reported to him in a timely manner, as he needs to review the results to determine the appropriate dose of warfarin to prescribe.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on surveyor observation, clinical record review, and staff interview, the facility failed to store drugs and biologicals in accordance with currently accepted professional principles for 1 of 2 medication rooms and 1 of 3 medication carts observed. Findings are as follows:Review of a facility policy titled, Storage of Medication dated 1/2026 states in part, Medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration.1. During a surveyor observation on 3/4/2026 at 8:07 AM, of the medication room on the Lilly Unit, in the presence of Registered Nurse (RN), Staff C and Licensed Practical Nurse, Staff K, revealed two bottles of Lorazepam 2 milligrams/milliliter (mg/ml) opened and undated. The manufacturer's instructions on the box state to discard the bottle 90 days after opening.During a surveyor interview immediately following the observation, Staff C and K acknowledged that the Lorazepam was opened and undated.2. During a surveyor observation on 3/4/2026 at 9:05 AM in the presence of Certified Medication Technician, Staff L of the medication cart on the Sun Unit, revealed one bottle of biotene mouth wash in a pump spray bottle without resident identifiers and without a cover for the mouth nozzle. Additionally, the nozzle was noted to have debris and hair on it.During a surveyor interview immediately following the observation, Staff L acknowledged that the bottle of biotene did not have any resident identifiers and the mouth nozzle was dirty.During a surveyor interview on 3/4/2026 at 11:39 AM with the Director of Nursing Services, she was unable to provide evidence that the facility stored drugs and biologicals in accordance with currently acceptable professional standards.