STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415099	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Lake Rehabilitation and Care Center	999 South Main Street Pascoag, RI 02859

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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 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 50004 Based on record review and staff interview, it has been determined that the facility failed to properly provide notice to residents and/or representatives informing them of when changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan related to the Skilled Nursing Facility Notice of Medicare Non-Coverage (NOMNC), in a timely manner for 3 of 4 residents reviewed who were discharged from a Medicare covered Part A stay with benefit days remaining, Resident ID #s 353, 354, and 355. Findings are as follows: Review of the Center for Medicare and Medicaid Services (CMS) Form, CMS-10123, titled, Form Instructions for the Notice of Medicare Non-Coverage (NOMNC), states in part, .A Medicare provider or health plan (Medicare Advantage plans and cost plans, collectively referred to as plans) must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services. The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily .Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process per Chapter 4, Section 260 of the Medicare Claims Processing Manual and Chapter 13, Sections 90.2-90.9 of the Medicare Managed Care Manual. A NOMNC must be delivered even if the beneficiary agrees with the termination of services . 1. Record review revealed that Resident ID #353's last covered day of Medicare Part A Services was on 3/13/2025 and s/he was discharged from the facility on 3/14/2025. Further record review failed to reveal evidence that the resident and/or resident representative was issued the NOMNC form. 2. Record review revealed that Resident ID #354's last covered day of Medicare Part A Services was on 3/12/2025 and s/he was discharged from the facility on 3/13/2025. Further record review failed to reveal evidence that the resident and/or resident representative was issued the NOMNC form. (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 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	3. Record review revealed that Resident ID #355's last covered day of Medicare Part A Services was on 11/10/2024 and was s/he discharged from the facility on 11/11/2024. Further record review failed to reveal evidence that the resident and/or resident representative was issued the NOMNC form. During a surveyor interview on 4/14/2025 at 2:27 PM, with the Minimum Data Set Coordinator, she acknowledged that Resident ID #s 353, 354, and 355 were not issued a NOMNC form. Additionally, she revealed that she did not know that the form was required when the resident agreed with the discharge. During a surveyor interview on 4/15/2025 at 1:39 PM, with the Administrator, she was unable to provide evidence that the resident and/or resident representative was issued the NOMNC form for Resident ID #s 353, 354, and 355.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46241 46539 Based on record review and staff interview, it has been determined that the facility failed to ensure that the Minimum Data Set (MDS) Assessment accurately reflected the resident's status for 2 of 2 residents reviewed for smoking, Resident ID #s 10 and 42, and 3 of 3 residents reviewed for restraints, Resident ID #s 9, 10, and 31. Findings are as follows: 1. Review of the Long-Term Care Facility Resident Assessment Instrument [RAI] 3.0 User's Manual last revised in October 2024 states in part, .Ask the resident if they used tobacco in any form during the 7-day look-back period. 2. If the resident states that they used tobacco in some form during the 7-day look-back period, code 1, yes. 3. If the resident is unable to answer or indicates that they did not use tobacco of any kind during the look-back period, review the medical record and interview staff for any indication of tobacco use by the resident during the look-back period . 1a. Record review revealed Resident ID #10 was admitted to the facility in January of 2025 with a diagnosis including, but not limited to, tobacco use. Record review revealed a care plan dated 1/21/2025 which revealed the resident uses a vape (a device used for inhaling vapor containing nicotine and flavoring) and tobacco products. Review of an MDS assessment dated [DATE], Section J, titled, Health Conditions revealed the resident was documented inaccurately as not using tobacco products during the 7-day look-back period. 1b. Record review revealed Resident ID #42 was admitted to the facility in September of 2023 with a diagnosis including, but not limited to, type 2 diabetes. Record review revealed a care plan dated 3/25/2025 which revealed the resident utilizes tobacco products. Record review revealed a Smoking Evaluation dated 3/5/2024, which revealed that the resident utilizes tobacco products. Review of an MDS assessment dated [DATE], Section J, titled, Health Conditions revealed the resident was documented inaccurately as not using tobacco products during the 7-day look-back period. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the RAI Manual dated October 2024 states in part, .The intent of this section is to record the frequency that the resident was restrained by any of the listed devices or an alarm was used, at any time during the day or night, during the 7-day look-back period. Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definitions in the appropriate categories .DEFINITION PHYSICAL RESTRAINTS Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body . 2a. Record review revealed Resident ID #9 was admitted to the facility in September of 2024 with a diagnosis including, but not limited to, dementia. Record review revealed a physician order dated 2/15/2025 for two 1/4 top side rails as an enabler for bed mobility and transfers, as needed while in bed. Review of an MDS assessment dated [DATE], Section P, titled, Restraints revealed the resident was coded for the use of bed rails as a restraint during the 7-day look-back period. 2b. Record review revealed Resident ID #10 was admitted to the facility in January of 2025 with a diagnosis including, but not limited to, obesity. Record review revealed a physician order dated 2/15/2025 for two 1/4 top side rails as an enabler for bed mobility and transfers as needed while in bed. Review of an MDS assessment dated [DATE], Section P, titled, Restraints revealed the resident was coded for the use of bed rails as a restraint during the 7-day look-back period. 2c. Record review revealed Resident ID #31 was readmitted to the facility in September of 2024 with a diagnosis including, but not limited to, dementia. Record review revealed a physician order dated 2/15/2025 for two 1/4 top side rails as an enabler for bed mobility and transfers, as needed while in bed. Review of an MDS assessment dated [DATE], Section P, titled, Restraints revealed the resident was coded for the use of a bed rails as a restraint during the 7-day look-back period. During surveyor interviews on 4/16/2025 at 10:28 AM and 4/17/2025 at 10:43 AM, with the MDS Coordinator, she revealed that Resident ID #s 10 and 42 are active smokers and utilize tobacco products. Additionally, she revealed that Resident ID #s 9, 10, and 31 utilize the side rails for bed mobility and transfers, but that they are not utilized as a restraint and do not meet the definition of a restraint. Furthermore, she revealed that the MDS Assessments for Resident ID #s 9,10, 31, and 42 were coded in error and would be modified with the correct information, after being brought to the facility's attention by the surveyor. During a surveyor interview on 4/17/2025 at 10:43 AM, with the Director of Nursing Services, she acknowledged that the above MDS assessments for Resident ID #s 9, 10, 31, and 42 were coded inaccurately. (continued on next page)

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	47279

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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 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. 47279 Based on record review and staff interview it has been determined that the facility failed to ensure that services being provided meet professional standards of practice relative to insulin administration for 1 of 3 residents reviewed, Resident ID #42. 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 the orders are in error or would harm the clients . Record review revealed that the resident was admitted to the facility in September of 2023 with a diagnosis including, but not limited to, type II diabetes. Record review revealed the following physician's orders: - Insulin lispro (fast-acting insulin that starts to work about 15 minutes after injection) 100 units/ milliliter (ml), administer 3 units subcutaneously (the layer of tissue just below the skin) daily from 11:30 AM until 1:00 PM. - Insulin lispro 100 units/mL, administer 3 units subcutaneous daily from 4:30 PM until 6:00 PM - Insulin lispro 100 units/mL, administer 3 units subcutaneous from 4:00 PM until 5:30 PM. Record review revealed that on the following dates and times, the insulin lispro was not administered as ordered: - 4/7/2025 from 4:30 PM until 6:00 PM, with a documented blood sugar of 83 milligrams (mg)/ deciliter (dL) - 4/11/2025 from 11:30 AM until 1:00 PM, with a documented blood sugar of 71 mg/dL - 4/14/2025 from 4:00 PM until 5:30 PM, with a documented blood sugar of 88 mg/dL Record review failed to reveal evidence that the provider was notified of the insulin lispro not being administered on 4/7, 4/11 or 4/14/2025. During a surveyor interview on 4/16/2025 at 10:38 AM with Licensed Practical Nurse, Staff A, she revealed that there are no parameters to hold the insulin in the order. Additionally, she revealed that the insulin should be given during the meal and if the medication was held, it should be reported to the provider. During a surveyor interview on 4/16/2025 at 10:34 AM with the Director of Nursing Services, she was unable to provide evidence that the insulin lispro was administered, as ordered, on 4/7/2025, 4/11/2025 and 4/14/2025. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 4/16/2025 at 10:49 AM with the Nurse Practitioner, Staff B, she revealed that she would expect the staff to follow the order as written and if the medication is held, she would expect the staff to notify her.

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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 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. 46539 Based on record review, resident and staff interview, it has been determined that the facility failed to ensure that each resident receives the necessary care and services to attain or maintain the highest practicable physical well-being for 1 of 2 residents reviewed for appointments, Resident ID #25. Findings are as follows: Record review revealed that Resident ID #25 was admitted to the facility in August of 2024 with diagnoses including, but not limited to, adult failure to thrive and repeated falls. Record review revealed a physician's order dated 1/27/2025 to obtain a neurology consult. Review of the progress notes revealed the following: - 1/27/2025 the resident's diagnoses were reviewed by the Nurse Practitioner (NP), Staff B, and a new order was obtained for a neurology consult - 1/27/2025 authored by Staff B, which revealed that speech therapy was to see the resident due to increase tremors and trouble swallowing, as well as his/her diet had been downgraded to a chopped texture with thin liquids. Additionally, a neurology consult was placed for tremors and dysphagia, (difficulty swallowing) with concerns for Parkinson's disease versus medication induced tremors - 4/10/2025 revealed the resident had upper extremity tremors with holding objects most of the time Review a document titled, Occupational Therapy Treatment Encounter Note(s) dated 1/29/2025, revealed that the resident complained of bilateral hand tremors and complained of having difficulty with drinking with a regular cup. Record review failed to reveal evidence that a neurology consult appointment was scheduled, attended, or declined by the resident. Review of the transport calendar for the year of 2025, with the Administrator, failed to reveal evidence that a neurology consult appointment was scheduled for Resident ID #25. During a surveyor interview on 4/16/2025 at 11:00 AM with Licensed Practical Nurse, Staff A, she revealed that she was unable to find evidence that the neurology appointment was scheduled, attended, or declined by the resident. During a surveyor interview on 4/16/2025 at 11:18 AM, with the Director of Nursing Services (DNS), she revealed that the person in charge of setting up appointments for the residents was unaware that Resident ID #25 was ordered or needed a neurology consult appointment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview and observation on 4/16/2025 at 11:25 AM, with the resident, in the presence of the DNS, the resident was observed to have tremors. Additionally, the resident revealed that s/he did not decline an appointment for a neurology consult. Furthermore, s/he revealed to the DNS and the surveyor that s/he was still having tremors and still needs to attend the neurology consult. During a surveyor interview on 4/18/2025 at approximately 12:30 PM with the DNS, in the presence of the Administrator, she was unable to provide evidence that the facility followed up and scheduled the neurology appointment as ordered by the provider on 1/27/2025.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47279 Based on surveyor observation and staff interview, it has been determined that the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, relative to the main kitchen. Findings are as follows: Review of the Rhode Island Food Code 2018 Edition 4-601.11, states in part, .Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. During surveyor observations on the initial tour of the main kitchen on 4/14/2025 at approximately 9:15 AM, in the presence of the Food Service Director (FSD), revealed the following: - A white colored component within the ice machine noted with black and pink matter, that was able to be removed by wiping it with a paper towel - A Kitchen Aid(R) appliance covered with a clear plastic bag, with a dark brown liquid matter leaking from a seam on the upper portion of the appliance onto the bag and appliance itself - An accumulation of a grease-like residue on the exhaust hoods above the stove and griddle. Additionally, a sticker was observed indicating that the hoods were last cleaned on 11/11/2024 During a surveyor interview immediately following the above observations on 4/14/2025 with the FSD, he acknowledged the discolored wipeable matter within the ice machine, the discolored liquid matter leaking from the kitchen appliance, and the grease-like accumulation on the exhaust hoods and indicated that they should be cleaned.

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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. 46241 Based on record review and staff interview, it has been determined that the facility failed to document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies which must be reviewed and updated as necessary, and at least annually. Findings are as follows: 1. Record review revealed a document titled, Facility Assessment last updated 3/10/2025, which revealed the following participants were involved in the completion of the Facility Assessment: - Administrator - Director of Nursing Services - Director of Environmental Services - Medical Director Record review failed to reveal evidence of the involvement of direct care staff including, but not limited to, Registered Nurse, Licensed Practical Nurse, Nursing Assistant, or a representative of the direct care staff, in the completion of the Facility Assessment. Further review of the Facility Assessment failed to reveal evidence that the facility solicited and considered input received from the residents, resident representatives, and family members. 2. Review of the Facility Assessment failed to reveal evidence that the facility developed and maintained a plan to maximize recruitment and retention of direct care staff. During a surveyor interview on 4/17/2025 at 10:50 AM, with the Administrator, she revealed that direct care staff, residents, family, or resident representatives were not involved in the completion of the Facility Assessment. Further, she acknowledged that the Facility Assessment did not include a plan to maximize recruitment and retention of direct care staff, per the regulation.