STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415104	A. Building B. Wing	05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roberts Health Centre Inc	25 Roberts Way North Kingstown, RI 02852

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observations, clinical record review, and staff and resident interviews, the facility failed to accurately assess, monitor, and provide timely treatment for 1 of 1 resident reviewed, Resident ID #45, after the resident reported toe pain and presented with multiple skin impairments. This failure placed the resident at risk for worsening skin breakdown, increased pain, and potential complications.Findings are as follows:Record review revealed Resident ID #45 was admitted to the facility in April of 2022 with a diagnosis including, but not limited to, peripheral neuropathy (nerve damage that can affect the sensation to the limbs).Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status score of 12 out of 15, indicating moderately impaired cognition. Further review of the MDS revealed the resident requires moderate assistance with putting on and taking off his/her socks and shoes.Review of the care plan dated 5/11/2022, last reviewed on 5/18/2026, revealed the resident is at risk for alteration in skin integrity related to a history to cellulitis (an infection of the skin) to the second toe of the right foot. Further review revealed interventions including, but not limited to, a foot cradle on the bed, monitoring the resident's skin with daily care, reporting changes and abnormal findings to the nurse and provider, applying skin prep as ordered, and conducting a skin assessment by a licensed nurse.Review of a podiatry evaluation dated 4/3/2026 revealed, a focused physical exam which included documentation that the resident's skin was thin and atrophic (thinning, fragile skin that is more prone to injury and slower to heal) with hammertoe contractures (a progressive bending deformity of the toes). Further review revealed a recommended treatment to offload with a band-aid or lambswool. Record review revealed the following progress notes:- 4/6/2026 - Followed up with podiatrist office in regard to.recommendation to ?keep offloading the toe with lambswool, pads or bandaids.' Message left for [family member].- 4/7/2026 - Follow up due to new shoes brought in by nephew - no redness to toes and [resident] prefers no padding to toe due to having space in toe box.Record review failed to revealed evidence that the provider was notified of the podiatry treatment recommendations on 4/3/2026.Record review revealed the following progress notes:- 4/17/2026 - the resident's right 3rd and 5th toes and the left 2nd toe continue with redness. Further review revealed improvement was noted and skin prep (a medical product with a film-forming agent that acts as a protective barrier) was continued as ordered.- 4/22/2026 - the resident's right 3rd and 5th toes and the left 2nd toe continue with redness, skin prep continued with no complaint of pain or discomfort. - 4/29/2026- the resident's right 3rd and 5th toes and the left 2nd toe continue with redness, skin prep continued with no complaint of pain or discomfort. Record review of a Weekly Skin/Body Assessment dated 5/5/2026 revealed, the resident's skin was intact and his/her knuckles to toes were pink blanchable [and] chronic.During a surveyor observation and interview on 5/18/2026 at 10:49 AM with Resident ID #45, during the initial tour of the facility, s/he revealed that his/her toes were red, painful, and had gotten worse over the last few weeks. The resident further stated that his/her toes were not as red yesterday and that s/he maybe needs something to cushion it. Surveyor observations revealed the resident's 3rd and 5th toes on the right foot and the 2nd toe of the left foot were reddened. The 3rd toe on the right foot was observed to be swollen. During the above interview, the resident initiated (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Actual harm Residents Affected - Few	his/her call light for assistance as s/he had unintentionally applied foot cleanser to his/her feet and needed assistance. A staff member entered the room at 10:59 AM to assist the resident. The resident indicated to the staff member that his/her toes were painful. The staff member stated to the resident that she would notify the nurse.Record review of a Weekly Skin/Body Assessment dated 5/19/2026, the day after the resident complained of redness and pain to the surveyor and the surveyor observation of the reddened toes, failed to reveal any skin impairments to the resident's feet. Further review revealed this assessment was completed by Registered Nurse (RN), Staff E.During a surveyor interview on 5/21/2026 at 9:30 AM with Resident ID #45, four days after the initial interview and observation, the resident revealed that his/her right foot is still painful and the facility had not done anything for it.During a surveyor interview on 5/21/2026 at 9:32 AM with RN, Staff E, she revealed that she was aware that the resident previously had issues with his/her toes, had been seen by podiatry, his/her family member brought him/her new shoes, and that a treatment was in place to apply skin prep daily. Additionally, she stated that the resident's toes were not red at the time of the skin assessment that she completed on 5/19/2026, in the presence of Nursing Assistant (NA), Staff F.During a surveyor interview on 5/21/2026 at 9:56 AM with NA, Staff F, she revealed that she assisted Resident ID #45 with a shower on 5/19/2026 at which time she observed the resident's toes to be reddened and painful while she was washing his/her feet. Staff F revealed that she informed the nurse and the nurse applied skin prep to the resident's toes following the nurse's skin check. Additionally, she revealed that she provides care for the resident weekly and that his/her toes have been reddened for a while.Record review failed to reveal evidence that the provider was notified of the painful, reddened toes prior to the surveyor bringing the concern to the facility's attention on 5/21/2026.Record review of a progress note dated 5/21/2026 at 10:36 AM revealed the following:- the resident was noted to have redness to his/her right foot in the outer 5th toe area, blanchable redness to the 3rd toe with a pinpoint scabbed area, and a white, dry, irritated area between the 4th and 5th toes.- the top of the resident's left foot 2nd toe was pink and blanchable- Nurse Practitioner (NP), Staff G was notified and gave new orders for a podiatry consult and treatments- orthopedic shoes removed and old shoes with cut out toe area applied- the resident complained of pain to his/her feet at nightRecord review revealed the following new orders were received on 5/21/2026, following the NP notification:- Apply Iodosorb (a wound gel) to the 3rd toe pinpoint area on the right foot and cover with a bandaid daily- Apply 2x2 gauze between the 4th and 5th toes on the right foot daily- Apply shoes with cutout in toes and remove at bedtimeDuring surveyor interviews on 5/21/2026 at 10:00 AM and at 12:28 PM with the Director of Nursing Services (DNS), she revealed that she would not expect a nurse to document redness to a resident's skin if the redness was chronic and to only document if there was a change or if pain was observed. She further revealed that she would expect the provider to be notified if there was a change in the resident's skin or if pain was assessed.Record review of a progress note received by email from the DNS, dated 5/22/2026 and authored by the NP, Staff G, revealed the resident was noted with an open area/pressure wound on his/her right 3rd toe, to continue with the wound dressing as ordered, and to follow up with the inhouse wound specialist. Further review revealed the resident was to avoid any pressure on the right foot and to begin Ultram 25 milligrams (a medication prescribed to treat pain) daily as needed for 14 days for pain management.The surveyor attempted to contact the resident's Nurse Practitioner (NP), Staff G, on 5/21/2026 at 12:18 PM and on 5/22/2026 at 1:34 PM. A message was left; however, no return phone call was received. Due to the facility's failure to accurately assess the resident's skin condition, recognize changes in skin integrity and complaints of pain, and timely notify the provider, the resident did not receive appropriate treatment and interventions in a timely manner, resulting in worsening skin impairment and further deterioration of the toes.

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F 0686 Level of Harm - 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 clinical record review and staff interview, the facility failed to timely notify the physician/provider of a newly identified pressure ulcer (localized damage to the skin and/or underlying soft tissue, usually over a bony prominence). As a result, the resident did not receive timely assessment, treatment, or implementation of appropriate wound care interventions, for 1 of 1 resident reviewed, Resident ID #20, who had an actual pressure injury, did not receive clinically indicated wound treatment for approximately 21 days. Consequently. the wound was later found to be infected with Methicillin-Resistant Staphylococcus aureus (MRSA- a bacteria that has become resistant to many commonly used antibiotics, including methicillin and other penicillin-related drugs). Findings are as follows:Record review of an undated facility policy titled, Skin Care Protocol states in part, .It is the policy of this facility to follow appropriate standards of care as they relate to residents' skin care; identification of those at risk, weekly skin checks, appropriate interventions and documentation.All residents will have a skin ?check'/assessment done on admission.The nurse will also complete the Braden Scale observation tool [an assessment used to determine a resident's risk for skin breakdown].weekly skin observations will be done for every resident regardless of their risk score.Monitoring: weekly observations will be done and maintained in the residents' medical record and care plans must be kept up to date with the resident's most recent condition and treatment. Documentation: when a pressure ulcer [an area of damaged skin or tissue caused when sustained pressure reduces blood flow to vulnerable areas of the body] exists, there must be daily monitoring. Documentation of the wound status shall include: an evaluation of the ulceran evaluation of the status of the dressing, if it is present (whether it is intact and whether drainage is present, is or is not leaking)the status of the area surrounding the ulcer (that can be observed without removing the dressing)the presence of possible complications such as; signs of increasing area of ulceration or soft tissue infection (for example, increased redness or swelling around the wound or increased drainage from the wound)With each dressing change or at least weekly, the following documentation must be present:Location and stagingSize, depth.exudate, if present; nature and frequencypain, if present; type, color, odor, and approximate amountwound bed color and type of tissue/character including evidence of healing (i.e. granulation), or necrosis (slough/eschar) [dead tissue] and description of wound edges and surrounding tissue (i.e. rolled edges, redness, hardness, maceration) as appropriate.The physician and the resident's representative shall be made aware of any pressure ulcers and significant changes in the resident's condition.Record review revealed Resident ID #20 was admitted to the facility on [DATE] with diagnoses including, but not limited to, thoracic vertebra wedge compression fracture (a small breaks or crack in the vertebrae), rheumatoid arthritis (a chronic autoimmune disease that primarily affects the joints, causing pain, swelling, and stiffness), and MRSA. Record review of a physician's order dated 4/3/2026, revealed to complete weekly skin checks and document findings in the weekly observation report. Record review of a Braden scale dated 4/10/2026, revealed that the resident was assessed to be at risk for the development of pressure ulcers.Record review of the weekly skin check dated 4/25/2026, revealed an open area was observed to the resident's right foot second metatarsal (one of five long bones located in the second toe). Record review of the weekly skin check dated 5/2/2026, revealed an open area to the right second toe.Additional review of the 5/2/2026 skin check revealed documentation that a new treatment was added. Record review of the weekly skin check completed 5/9/2026 revealed an open area approximately 0.5 inches to the right foot second metatarsal.Additional record review failed to reveal evidence of the pressure ulcer stage, description, or characteristics were documented, per facility policy.Record review failed to reveal evidence the provider was notified, that a treatment order was obtained, or that a treatment was provided for the pressure ulcer noted on 4/25, 5/2 and 5/9/2026. Record review of the weekly skin check completed 5/16/2026 revealed a pressure ulcer (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	was observed to the right foot, second toe.Additional record review failed to reveal evidence of the pressure ulcer stage, description, or characteristics were documented, per facility policy.Record review revealed a physician's order dated 5/16/2026 to cleanse the right second toe with saline, pat dry and apply medihoney (a topical wound gel), and cover with clean dressing daily.Record review failed to reveal evidence that a treatment order was implemented for the newly identified pressure ulcer to the resident's right foot second toe from 4/25/2026, when it was initially identified until 5/16/2026. This indicates the resident's pressure ulcer went without a treatment for 21 days.Further record review revealed a care plan initiated on 5/16/2026, indicating the resident has an open area to the right foot second toe. Interventions include, but are not limited to, following up with the wound specialist the next visit. During a surveyor interview on 5/20/2026 at 2:49 PM with Licensed Practical Nurse, (LPN), Staff A, she acknowledged that she observed an open area to the resident's right foot second toe on 4/25/2026 and on 5/9/2026 during their weekly skin check and failed to document the pressure ulcer stage, description, or characteristics. Additionally, she acknowledged she failed to notify the provider or obtain a treatment for the pressure area.During surveyor interviews on 5/20/2026 at 3:05 PM and 5/21/2026 at 8:29 AM with LPN, Staff B, he acknowledged that he observed a wound to the resident's right foot second toe on 5/2/2026 during their weekly skin check. Additionally, he acknowledged that although he documented that a new treatment order was obtained, no treatment was in place for the resident's right second toe wound. Further, he acknowledged he failed to document the staging, measurements, description, and characteristics of the wound.Record review of a wound evaluation progress note dated 5/20/2026, authored by the wound care, Nurse Practitioner revealed, that a consultation was requested for evaluation of an open wound on the patient's right foot second toe. On evaluation the right foot second toe is noted with a full thickness (a wound that extends into the deep layers of the skin such into the fatty tissue) open wound, measuring 0.8 centimeters (cm) by 1.2 cm by 0.2 cm, with moderate serosanguinous drainage (a bloody/clear fluid). Additionally, review revealed the presence of redness, swelling, and warmth to the surrounding tissue. The wound bed is a mix of granulation (healing) tissue and slough (dead) tissue, and the resident endorses mild discomfort to the wound bed. The provider ordered a wound culture for potential infection. Furthermore, record review of the progress note revealed plan of care is to cleanse with Vashe (a wound cleanser), apply honey gel and calcium alginate with silver (an absorbent wound dressing) to the wound bed, and cover with bordered gauze daily. Record review revealed a wound culture was obtained of the resident's right foot, second toe on 5/20/2026.During surveyor interviews on 5/20/2026 at 12:19 PM and on 5/21/2026 at 10:04 AM with Resident ID #20, s/he indicated that the ulcer on his/her right foot second toe has been there for a few weeks and only recently staff began putting a bandage on it. Additionally, s/he indicated that s/he experiences pain when pressure is applied to the ulcer. During surveyor interviews on 5/21/2026 at 9:44 AM and 10:32 AM, the Physician's Assistant (PA) stated she was not made aware of the pressure ulcer to the resident's right second toe until sometime within the past week. She further indicated that she did not evaluate the wound until 5/21/2026. The PA also reported that when she assessed the area, she did not remove the dressing; however, a dressing was in place at the time of evaluation. Upon observation, PA noted that drainage was seeping through the dressing and that the toe was red and swollen. During a surveyor interview on 5/21/2026 at 11:46 AM. with the Physician. he revealed that he had not been made aware that the resident had a new pressure ulcer until it was brought to his attention by the surveyor. Additionally, he indicated it would be his expectation for nursing to notify him and/or the PA of a newly identified pressure ulcer to obtain an order and provide a treatment. During a surveyor interview on 5/21/2026 at 12:01 PM, with the Director of Nursing Services, she was unable to provide documentation of the pressure injury stage, description, or characteristics until 5/20/2026. Additionally, she acknowledged that the resident did not have a treatment order for his/her wound that was identified on 4/25/2026 until 5/16/2026, 21 days after it was identified.Review of a wound culture report received by the surveyor via email from the facility on (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	5/26/2026 revealed that a culture of the resident's second toe was obtained on 5/20/2026. The culture results, received on 5/23/2026, indicated that the resident's ulcer was infected with MRSA. Due to the facility's failure to timely notify the physician/provider of a newly identified pressure ulcer, the resident did not receive timely assessment, treatment, or implementation of appropriate wound care interventions. As a result, the resident went without clinically indicated wound management for approximately 21 days, during which time the wound progressed without appropriate oversight, resulting in the resident experiencing pain, infection, and avoidable clinical decline.

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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. Based on surveyor observation and staff interview, the facility failed to properly store and prepare food in accordance with professional standards for food service safety relative to the main kitchen and 1 of 2-unit ice machines.Findings are as follows:1) Record review of Rhode Island Food Code, 2022 Edition, Section 3-501.17 states in part, .READY -TO-EAT-TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the premises, sold, or discarded when held at a temperature of 5 degrees Celsius or 41 degrees Fahrenheit or less for a maximum of 7 days. The day of preparation shall be counted as Day 1 .Surveyor observation of the refrigerator during the initial tour of the kitchen on 5/18/2026 at 8:48 AM revealed the following:2 packages of Hormel natural choice roast beef with a use or freeze by date of 4/14/2026During a surveyor interview immediately following the above observations with Cook, Staff C, he acknowledged that the above items were expired and should have been discarded.2) Record review of The Rhode Island Food Code 2022, Edition 4.601.11 reads in part, .(A) equipment food contact surfaces .shall be clean to sight .During a surveyor observation of the facility ice machine located in the second-floor kitchenette during the initial tour on 5/18/2026 at approximately 9:15 AM, revealed a pink substance located on the white shield on the inside of the machine where the ice is dispensed.During surveyor interviews with the Food Service Director on 5/18/2026 at 9:21 AM and 5/21/2026 at 8:30 AM, he acknowledged the pink substance inside of the ice machine and that it needed to be cleaned. Additionally, he acknowledged that the roast beef was past its expiration date and should have been discarded.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to conduct a comprehensive, and accurate assessment of each resident's functional capacity, needs, strengths and goals for 1 of 2 resident's reviewed for the timely completion and submission of the admission Minimum Data Set (MDS) assessment, Resident ID #50. Additionally, the MDS assessments failed to reveal coding for 2 of 2 residents who receive continuous oxygen, Resident ID #s 1 and 2, and for 6 of 6 residents who utilize safety alarms, Resident ID #s 7, 13, 30, 36, 37, and 38.Findings are as follows:1. Record review revealed Resident ID #50 was admitted to the facility on [DATE], with a diagnosis including, but not limited to, multiple rib fractures.Record review of an admission MDS assessment dated [DATE] revealed that as of 5/20/2026, the comprehensive assessment was incomplete.2a. Record review revealed Resident ID #1 was admitted to the facility in March of 2026 with diagnoses including but not limited to, chronic obstructive pulmonary disease, and dependence on supplemental oxygen.Record review revealed an order dated 4/1/2026 for continuous oxygen at 3-4 liters via nasal canula every shift.Record review of the April and May Medication Administration Records (MAR) revealed documentation that from 4/1 through 5/20/2026, the resident was administered oxygen continuously.Record review of the resident's admission MDS assessment dated [DATE] failed to reveal evidence that the resident was receiving oxygen therapy.2b. Record review revealed Resident ID #2 was admitted to the facility in December of 2025 with a diagnosis including but not limited to, chronic respiratory failure with hypoxia.Record review revealed an order dated 12/26/2025 to change the oxygen tubing and/or humidifier and label both every week on Thursday.Record review revealed an order dated 4/8/2026 for continuous oxygen at 2-4 liters via nasal canula every shift.Record review of May MAR revealed documentation that from 5/1 through 5/20/2026, the resident was administered oxygen continuously.Record review MDS Assessments dated 1/14/2026 and 3/3/3026 failed to reveal evidence that the resident was receiving oxygen therapy.3a. Record review revealed Resident ID # 7 was admitted to the facility in July of 2022 with diagnoses including, but not limited to, dementia, and abnormalities of gait and mobility.Record review revealed an order dated 11/19/2025 to check that the bed alarm is functioning every shift.Record review of the Significant Change MDS assessment dated [DATE] failed to reveal evidence that alarms were utilized for the resident.3b. Record review revealed Resident ID #13 was admitted to the facility in December of 2024 with diagnoses including, but not limited to, dementia and repeated falls.Record review revealed the following orders:2/5/2025- check that the bed alarm is in place and operational3/12/2025- check that the chair alarm is in place and operationalRecord review of the MDS assessments dated 5/30/2025, 8/22/2025, 11/21/2025 and 2/6/2026 failed to reveal evidence that alarms were utilized for the resident.3c. Record review revealed Resident ID #30 was admitted to the facility in December of 2024 with diagnoses including, but not limited to, dementia and repeated falls.Record review revealed the following orders:2/6/2026- check the placement and function of bathroom door alarm every shift3/4/2026- check the placement and function of floor mat alarms twice every shift3/4/2026- check the placement and function of wheelchair alarm every shiftRecord review of the Quarterly MDS assessment dated [DATE] failed to reveal evidence that alarms were utilized for the resident.3d. Record review revealed Resident ID #36 was admitted to the facility in April of 2026 with diagnoses including, but not limited to, Alzheimer's disease and muscle weakness.Record review revealed the following orders:4/26/2026- check the functioning and the placement of the bed alarm4/20/2026- Chair alarm to recliner. This order was discontinued on 5/1/2026Record review of the admission MDS assessment dated [DATE] failed to accurately document that alarms were utilized for the resident.3e. Record review revealed Resident ID #37 was admitted to the facility in May of 2024 with diagnoses including, but not limited to, Alzheimer's disease and a history of falling.Record review (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed the following orders:4/23/2026- ensure floor alarm is in place and functioning properly.3/4/2025- chair alarm to recliner. This order was discontinued on 5/14/2026.6/16/2024- bed alarm in place and functioning when resident is in bed as tolerated. This order was discontinued on 5/14/2026.Record review of the MDS assessments dated 12/12/2025 and 3/13/2026 failed to reveal evidence that alarms were utilized for the resident.3f. Record review revealed Resident ID #38 was admitted to the facility in April of 2025 with a diagnosis including, but not limited to, dementia.Record review revealed an order dated 11/10/2025 to check that the bed alarm is functioning.Record review of an Annual MDS assessment dated [DATE] failed to reveal evidence that alarms were utilized for the resident.During a surveyor interview on 5/20/2026 at approximately 1:45 PM with MDS Coordinator, Staff D, she was unable to provide evidence that the admission assessment for Resident ID #50 was completed within 14 days, as required. Additionally, she revealed that the MDS Assessments should include oxygen if oxygen was administered to the resident during the lookback period; however, she was unable to provide evidence that oxygen usage was documented on the MDS Assessments for Resident IDs #1 and #2. Lastly, she revealed that the MDS assessments should include alarms that are utilized for the residents during the lookback period, but was unable to provide evidence that the alarm usage was documented on the MDS Assessments for Resident ID #s 7, 13, 30, 36, 37 and 38.