STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415106	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Antoine Residence	10 Rhodes Avenue North Smithfield, RI 02896

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure that a resident received adequate assistive devices and failed to communicate changes in recommended assistive devices to caregivers to prevent accidents, for 1 of 2 residents reviewed who utilized a stand aid (a device used to assist individuals in transitioning from a sitting to a standing position and transferring from surface to surface) for transfers, Resident ID #165.Findings are as follows:A. Record review of a facility policy titled Falls Prevention & Management last revised 10/2022 states in part, .It is the policy of [the facility] that the facility will ensure that each resident receive adequate supervision and assistive devices to prevent accidents.Record review of a procedure titled Guidelines on Tasks to Complete After a Fall states in part, .submit a rehab screen if the resident is not on Hospice services.Record review revealed Resident ID #165 was admitted to the facility in April of 2018 with diagnoses including, but not limited to, hemiplegia (severe weakness or total paralysis of one entire side of the body) and hemiparesis (the inability to move one side of the body) following unspecified cerebrovascular disease (a stroke), partial traumatic amputation of left foot, and vascular dementia.Review of an Annual Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status score of 15 out of 15, indicating intact cognition. Further review revealed that the resident was non-ambulatory and dependent on staff for all transfers.Record review of the resident's progress notes revealed the following entries: - 10/17/2025 - The resident lost balance in stand aid. The Nursing Assistant (NA) was with resident using stand aid when resident slid to the floor during the transfer. - 10/31/2025 - While being assisted by a NA the resident fell backwards from the stand aid. - 11/1/2025 - While using the stand aid, the resident was noted to be non-compliant with instructions on proper use of stand aid. - 12/29/2025 - While receiving care in his/her room, the resident was lowered to the floor by two NA's during a transfer using the stand aid. The resident was noted to be non-compliant with directions when using stand aid and a high risk for falling during transfers. - 12/30/2025- The resident was lowered to the floor by staff while in the main shower room. Staff reported that his/her knees were buckling. A referral for physical rehab was made.During a surveyor interview on 1/29/2026 at 9:18 AM with Unit Manager, Registered Nurse, Staff A, she revealed that following a fall it is standard to submit a rehab screen as part of fall guidelines and any changes in a resident's status are communicated with the interdisciplinary team. She further indicated that all screens were scanned into the residents Electronic Medical Record and could be referenced there.Record review failed to reveal evidence that rehab screens were submitted after the resident's falls on 10/31/2025, 11/1/2025, 12/29/2025, and 12/30/2025 per the facility's fall procedure.During a surveyor interview on 1/29/2026 at 9:43 AM with the Director of Rehabilitation, she was unable to provide evidence rehab screens were completed following the above-mentioned falls as indicated by the fall guideline policy. She further revealed that she was unaware that the (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had sustained falls from the stand aid, that the resident was noted to be non-compliant with instructions during use of the stand aid, and that the resident had experienced knee buckling during transfers using the device.B. Record review of a document titled Assignment #1 provided on 1/29/2026, revealed that the resident required assistance of 1-2 staff persons with use of a stand aid for all transfers.Record review of a care plan for falls last revised on 12/30/2025, revealed to utilize a stand aid for transfers.Record review of a progress note dated 1/13/2026, revealed that the residents returned to the facility following a hospitalization for change in medical status. The resident was evaluated by rehab, and a recommendation was made to use a Hoyer lift (a hydraulic-powered device that holds the patient in a hammock-type sling to lift them completely up and transfer them to a new surface) for all transfers.During a surveyor interview on 1/29/2026 at 9:18 AM with Unit Manager, Registered Nurse, Staff A, she revealed that the resident's transfer status and assistive device needed for transfers are communicated to the NAs via the assignment sheet and white boards located in the resident's rooms. She further indicated that the residents care plans are revised to reflect current transfer status, changes, and interventions following a fall.During a surveyor interview on 1/29/2026 at 9:43 AM with the Director of Rehabilitation, she revealed that it was recommended by the rehab department on 1/13/2026 that the staff utilize a mechanical full body Hoyer lift and 2 staff members for transfers due to the resident's functional decline. She further indicated that this had been communicated in writing to nursing and that the resident's whiteboard had been updated. Record review of a document titled Transfer Status Form dated 1/13/2026, signed by the Occupational and Physical Therapist, revealed that the resident required a full body Hoyer lift with assistance from 2 staff persons for transfers.Record review failed to reveal evidence that the residents care plan had been revised. Additional record review failed to reveal evidence the Assignment sheet, used to communicate the residents functional status and assistive device needed for transfers to NAs, had been revised to reflect the change in residents status on 1/13/2026.During a surveyor interview on 1/30/2026 at 9:00 AM with Staff A, she revealed that the residents change of status had been provided to another nurse on 1/13/2026. She acknowledged that the residents transfer status had not been updated on the NAs assignment sheet. She further acknowledged that the residents care plan had not been revised to reflect the 1/13/2026 recommendation to use a mechanical Hoyer lift.During a surveyor interview on 1/30/2026 at 9:49 AM with the Director of Nursing Services, she revealed that it is her expectation that rehab screens would have been provided to the rehab department following each fall or a change in functional status, per the fall guidelines and policy. Additionally, she acknowledged that the facility failed to clearly communicate the resident's status with NAs and should have to prevent risks of accidents from occurring during transfers.

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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 1 of 3 residents reviewed for oxygen use, Resident ID #76. Findings are as follows:According to Lippincott Nursing Procedure Ninth Edition 2023, page 621, states in part, .Verify the practitioner's order for the oxygen therapy, because oxygen is considered a medication or therapy and should be prescribed .Review of an undated facility policy titled, Oxygen Therapy Procedure states in part, .A physician's order is required.make sure that the oxygen flow rate is set at the amount specified.Documentation: date and time of oxygen administration.rate of flow.Record review revealed the resident was admitted to the facility in June of 2022 and readmitted in January of 2026 with diagnoses including, but not limited to, pneumonia and acute respiratory failure (a life-threatening condition where the lungs suddenly can't effectively exchange oxygen and carbon dioxide, leading to dangerously low blood oxygen or high carbon dioxide levels).Review of a physician's order dated 12/13/2025 revealed to administer oxygen at 2 liters (L) as needed (prn).Surveyor observations revealed the resident was receiving 3L of oxygen instead of 2L, as ordered on the following dates and times:- 1/27/2026 at 10:27 AM and at 12:24 PM- 1/28/2026 at 11:20 AM- 1/29/2026 at 10:20 AMDuring a surveyor observation and interview conducted on 1/29/2026 at 10:39 AM in the presence of Registered Nurse Staff B, she stated that the resident was receiving oxygen at 3L per minute and that there was an order for 3L per minute. Upon the surveyor's request, Staff B reviewed the resident's electronic medical record and subsequently acknowledged that the physician's order was for oxygen at 2L per minute, not 3L per minute as previously stated. During a surveyor interview on 1/29/2026 at 10:49 AM with the Unit Manager, Staff C, she acknowledged the resident's oxygen order indicated 2L and not 3L, as observed. During an additional surveyor observation on 1/29/2026 at 11:30 AM, the resident was observed continuing to receive 3L of oxygen instead of 2L, as ordered. This observation occurred after the surveyor had previously notified the facility that the resident was receiving oxygen at an incorrect flow rate. During a surveyor interview on 1/29/2026 at 1:38 PM with the Director of Nursing Services, she indicated that she would have expected the resident to be receive 2L of oxygen, as ordered.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on clinical record review and staff interview, the facility failed to establish an Infection Prevention and Control Program (IPCP) that includes, at a minimum, an antibiotic stewardship program which includes antibiotic use protocols and a system to monitor antibiotic use to ensure that residents who require an antibiotic, are prescribed the appropriate antibiotic for 5 of 6 residents reviewed for antibiotic use, Resident ID #s 5, 13, 16, 89, and 165.Findings are as follows:According to the Centers for Disease Control and Prevention (CDC) document titled, The Core Elements of Antibiotic Stewardship for Nursing Homes states in part, Perform antibiotic 'time outs.' .Nursing homes should have a process in place for a review of antibiotics by the clinical team two to three days after antibiotics are initiated to answer these key questions:Does this resident have a bacterial infection that will respond to antibiotics?If so, is the resident on the most appropriate antibiotic(s), dose, and route of administration?Can the spectrum of the antibiotic be narrowed or the duration of therapy shortened (i.e., de-escalation)?Would the resident benefit from additional infectious disease/antibiotic expertise to ensure optimal treatment of the suspected or confirmed infection . 1. Record review revealed that Resident ID #5 was admitted to the facility in August of 2025 with a diagnosis including, but not limited to, dementia. Record review revealed a physician's order for Doxycycline (an antibiotic) 100 milligrams (mg) twice daily for 10 days, from 12/28/2025 through 1/8/2026.Additional record review failed to reveal evidence that an antibiotic time out or a review at day three was conducted.2. Record review revealed that Resident ID #13 was admitted to the facility in March of 2023 with a diagnosis including, but not limited to, diverticulitis of the large intestine (inflammation or infection of irregular bulging pouches in the intestines).Record review revealed a physician's order for Doxycycline 100 mg twice daily for seven days, from 12/28/2025 through 1/4/2026. Additional record review failed to reveal evidence that an antibiotic time out or a review at day three was conducted.3. Record review revealed that Resident ID #16 was admitted to the facility in January of 2024 with a diagnosis including, but not limited to, pneumonia. Record review revealed a physician's order for Cefpodoxime Proxetil (an antibiotic) 200 mg twice daily for seven days, from 1/24/2026 through 1/31/2026. Additional record review failed to reveal evidence that an antibiotic time out or a review at day three was conducted.4. Record review revealed that Resident ID #89 was admitted to the facility in May of 2025 with a diagnosis including, but not limited to, dementia.Record review revealed a physician's order for Clindamycin HCL (an antibiotic) 300 mg three times a day for 10 days, from 1/20/2026 through 1/30/2026. Additional record review failed to reveal evidence that an antibiotic time out or a review at day three was conducted.5. Record review revealed that Resident ID #165 was admitted to the facility in April of 2018 with a diagnosis including, but not limited to, sepsis.Record review revealed a physician's order for Meropenem intravenous solution reconstituted (an antibiotic) 500 mg every 12 hours for six days, from 1/13/2026 through 1/19/2026. Additional record review failed to reveal evidence that an antibiotic time out or a review at day three was conducted.During a surveyor interview on 1/29/2026 at 11:41 AM with the Infection Preventionist, she indicated that antibiotics are discussed verbally at staff meetings however antibiotic timeouts or reviews are not documented unless a physician's order is in place.During a surveyor interview with the Director of Nursing Services on 1/29/2026 immediately following the above interview, she could not provide evidence that antibiotic timeouts or reviews were completed.