| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 415108 | A. Building<br>B. Wing | 12/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Harris Health Care Center North | 60 Eben Brown Lane<br>Central Falls, RI 02863 |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>Based on surveyor observation, clinical record review, and staff and resident interviews, the facility failed to inform residents how to file a grievance or complaint. Additionally, the facility failed to implement the grievance policy to ensure the prompt resolution of all grievances, for 9 of 9 residents reviewed during the Resident Council meeting, Resident ID #s 4, 6, 9,14, 20, 22, 24, 26, and 29.Findings are as follows:Review of an undated document titled Grievance procedure/Conflict Resolution states in part, .Any person with a grievance, complaint or concern is urged to complete a ?Grievance/Complaint form' that is available at each nurses' station or voice it directly to the Administrator/designee .staff members are responsible to assist as necessary.the grievance/complaint is to be directed to the department head responsible to investigate it.the department head is to complete the investigation and provide a written response to it within 3 business days of receipt. A copy of the response is to go to the person filing the grievance/ complaint.During the Resident Council meeting on 12/4/2025 at approximately 1:30 PM, Resident ID #s 4, 6, 9,14, 20, 22, 24, 26, and 29 revealed that they were unaware of the grievance procedure and policy. Additionally, they revealed that staff had not reviewed instructions on how on to file a grievance verbally or in writing with them.During a surveyor interview on 12/4/2025 at 2:05 PM, with the Activities Director, who assists with the Resident Council, she revealed that she had not discussed or provided information to the residents on how to file a grievance.During a surveyor interview on 12/4/2025 at 2:25 PM, with the Administrator, he acknowledged that the facility had not made the information available to the residents on how to file a grievance or complaint. He further acknowledged that the facility does not utilize the grievance procedure, as required, and should have. |

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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure that food is stored and distributed in accordance with professional standards for food service safety, relative to the main kitchen.Findings are as follows:1) Record review of the FDA Food Code, 2022 Edition, Section 3-501.17 states in part, .READY -TO-EAT-TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and help 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 .During the initial tour of the main kitchen on 12/3/2025 at approximately 8:40 AM, with the Food Service Director (FSD), the following was observed: - One opened 5.3-ounce (oz) container of Light and Fit brand apple pie flavored yogurt, without a discard date - Two ready to use pie crusts, without a discard date - Two 7.25 oz. boxes of macaroni and cheese, with a discard date of 6/21/2025 - One 20 oz. squeeze bottle of Welch's brand grape jelly with manufacturer's instructions to refrigerate after opening was opened and stored by the stove. - One 10 oz. bottle of steak sauce with manufacturer's instructions to refrigerate after opening was opened and stored by the stove. - One 16 oz. box of Domino's brand sugar, 1/2 full, with a discard date of 1/4/2025 - One box containing four 0.3 oz bottles of food coloring, with an illegible date - One 16 oz bottle of ground nutmeg, 1/2 full, with a discard date of 7/14/2021 - One 16 oz bottle of black pepper, 1/3 full, with a discard date of 1/25/2023During a surveyor observation of the dry storage area on 12/4/2025 at 2:11 PM in the presence of the FSD, the following was revealed: - Nine 46 oz boxes of cranberry juice cocktail concentrate, with a use by date of 12/16/2023 - Ten 46 oz boxes of nectar thickened water, with a use by date of 11/5/2025 - Twelve 46 oz boxes of orange juice concentrate, with a use by date of 1/12/2024During a surveyor interview with the FSD immediately following the above observations, he acknowledged that the above-mentioned items should have been dated, stored, and discarded as indicated.2) Record review of the FDA Food Code, 2022 Edition, section 4-601.11 states in part, .(A) EQUIPMENT FOOD-CONTACT SURFACES .shall be clean to sight and touch .(B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT .shall be kept free of encrusted grease deposits and other soil accumulations. (C) NON-FOOD CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris .During the initial tour of the main kitchen on 12/3/2025 at approximately 8:40 AM, with the FSD, the following was observed: - The three-burner coffee maker had a visible accumulation of food debris on the outside of the appliance and there was a thick black residue where the water is dispensed into the basket of coffee grounds for brewing - The shelf containing the juice concentrate boxes had a visible accumulation of a sticky substance in front of them. The shelf also had a visible accumulation of dirt and food debris - The three hoses which connect the boxed juice concentrates to the juice dispensing gun were sticky to touch. The valve which connected the boxes to the hoses also had a visible accumulation of dried juice concentrate - The handheld juice dispenser had a visible accumulation of dark matter inside the nozzle where the juice is dispensed - The red knobs on the gas stove had visible accumulations of a black greasy matter. The exterior of the stove had an accumulation of visible food residue - The hood above the stove had a visible accumulation of a black greasy residue. The sticker on the exterior of the hood indicated that the hood had last been cleaned and inspected on 12/3/2024During a surveyor interview with the FSD on 12/3/2025 at 9:25 AM, he acknowledged the above observations. He revealed that equipment is cleaned quarterly by an outside company and that daily cleaning is not being conducted. 3) Record review of FDA Food Code, 2022 Edition, Section 7-202.12 states in part, Medicines belonging to EMPLOYEES.that required refrigeration and are to be stored in a FOOD refrigerator shall be: (A) Stored in a package or container and kept inside a covered, leakproof container that is<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | identified as a container for the storage of medicine.During the initial tour of the main kitchen on 12/3/2025 at approximately 8:40 AM, with the FSD, a Lantus insulin pen (a long-acting insulin used to help manage blood sugar levels) was observed to be stored on the top shelf of the refrigerator utilized to store food for all the residents in the facility. The Lantus pen was open, unlabeled and undated, and was noted to be used.During a surveyor interview immediately following the above-mentioned observation with the FSD, he revealed that the insulin pen was his personal pen and that he stores it on the top shelf of the refrigerator. Additionally, he acknowledged that the pen had been used by him in the facility. Furthermore, he acknowledged that the insulin pen was not labeled and should not be stored in the main kitchen refrigerator which is utilized for the facility's resident's food. |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>Based on clinical record review and staff interview, the facility failed to develop, implement, and maintain an effective, comprehensive, data-driven Quality Assurance and Performance Improvement (QAPI) program that focuses on indicators of the outcomes of care and quality of life relative to making a good faith attempt to correct deficiencies related to trauma informed care and the cleanliness of the kitchen. Findings are as follows:Review of a facility policy titled, Quality Assurance Performance Improvement dated 1/1/2018 states in part, The QAPI plan has been established to provide a planned, systemic, and ongoing quality improvement process designed to objectively monitor and evaluate the quality of resident care and to pursue opportunities for organizational improvement.1) Record review of a 2567 (Centers for Medicare & Medicaid Services Statement of Deficiencies) dated 10/11/2024 revealed that the facility was cited for trauma informed care. Additional review of the 2567 revealed that the facility submitted a plan of correction to the Rhode Island Department of Health on 11/7/2024 that states in part, .We have provided education to the social service designee regarding.referral to an appropriate provider and the development of a trauma informed care plan as needed.the audits will be conducted on a routine basis and the results shared with the QAPI committee for no less than 3 months; at which time we will determine the need/frequency to continue formal audits.Review of the QAPI binder for 2024 revealed three audits dated 10/9/2024 for Trauma Informed Care. Further review failed to reveal evidence of any further audits, actions, measurements, or tracking to ensure efforts for improvement with trauma informed care.Review of the QAPI binder for 2025 failed to reveal evidence of any actions, measurements, or tracking to ensure efforts for improvement related to trauma informed care.Record review by the survey team revealed continued concerns identified related to trauma informed care during the 2025 recertification survey.2) Record review of the QAPI 2025 binder revealed documents titled, QAPI-Dining Department dated March, April and June 2025 that states in part, .Concern/Problem: Completion of Dietary cleaning assignments. Findings: Daily cleaning duties are not being completed daily by the Dietary Department.continue to monitor and document.continue to audit the following months.Review of the QAPI binder for 2025 failed to reveal evidence of any actions, measurements, or tracking to ensure efforts for improvement related to the cleanliness of the kitchen.Surveyor observations of the kitchen during the 2025 recertification survey revealed continued concerns with the cleanliness of the kitchen.During a surveyor interview on 12/5/2025 at approximately 10:00 AM, with the Administrator during the QAPI task, he acknowledged there was not an ongoing QAPI related to trauma informed care or the cleanliness of the kitchen. The Administrator failed to provide evidence of a good faith attempt to correct the concerns related to trauma informed care identified during the 2024 recertification survey. Additionally, the Administrator was unable to provide evidence of daily cleaning logs or audits for the kitchen.Cross reference F 699 and F 812 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>Based on clinical record review and staff interview, the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections relative to the storage of staff insulin in the main kitchen, failed to clean with an Environmental Protection Agency (EPA) approved disinfectant, failed to prevent the spread of infection during 1 of 1 wound observation for Resident ID #5, and failed to report a cluster of scabies to the Rhode Island Department of Health affecting Resident ID #'s 11, 14, 23, 28 and 30. Furthermore, the facility failed to implement a water management program (WPM) based upon industry standards and/or the Centers for Disease Control and Prevention (CDC) and to perform and document specified testing for the prevention of Legionella disease (a very serious type of lung infection caused by the bacteria called Legionella which can be found in water).Findings are as follows:1) Record review of the Food and Drug Administration (FDA) Food Code, 2022 Edition, Section 7-207.12 states in part, .Medicines belonging to EMPLOYEES.that required refrigeration and are to be stored in a FOOD refrigerator shall be: (A) Stored in a package or container and kept inside a covered, leakproof container that is identified as a container for the storage of medicines.During the initial tour of the main kitchen on 12/3/2025 at approximately 8:40 AM, with the Food Service Director (FSD), an open unbagged or boxed single Lantus insulin pen (a long-acting insulin used to help manage blood sugar levels) was observed to be stored on the top shelf of the fridge that is utilized for food for all of the resident's in the facility. During a surveyor interview immediately following the above-mentioned observation, with the FSD, he revealed that the insulin pen was his personal pen and that he stores it on the top of the shelf of the fridge. Additionally, he acknowledged that the pen has been used by him in the facility. Furthermore, he acknowledged that the insulin pen should not be stored in the main kitchen refrigerator that is utilized for the facility's resident's food.2) Review of a policy titled Reportable Diseases last revised 3/10/2021, states, It is the policy of this facility to monitor the health of all residents, to take appropriate steps to safeguard resident health and to report to the RI department of Health any threat to the general health of the residents or to the community at large.whenever a threat to the general health of the residents of this facility is suspected OR an illness is identified within the facility which could affect the general health of the residents of the facility .it is the responsibility of the facility administrator or the Medical Director or the ICP [infection preventionists] to contact the RI Department of Health.During the initial tour on 12/3/2025 multiple residents complained about a potential scabies outbreak. During the infection control task on 12/4/2025 at 11:51 AM, with the Director of Nursing (DNS), she revealed that there was confirmed scabies cases September and November 2025. Additionally, she revealed that there was one confirmed Nursing Assistant (NA), Staff F, and three NA's that were treated.Review of the provided Scabies tracking list revealed the following:-Resident ID #23 was treated with permethrin cream on 9/16/2025 for a diagnosis of scabies-Resident ID #14 was treated with permethrin cream on 9/16/2025 for a diagnosis of scabies-NA, Staff F, was treated with permethrin cream on 9/16/2025 for a diagnosis of scabies-NA, Staff G, was treated with permethrin cream on 9/16/2025 for a diagnosis of scabies-Resident ID #11 was treated with permethrin cream on 11/12/2025 for a diagnosis of scabies-Resident ID #28 was treated with permethrin cream on 11/18/2025 for a diagnosis of scabies-Resident ID #30 was treated with permethrin cream on 11/18/2025 for a diagnosis of scabies-NA, Staff H, was treated with permethrin cream on 11/19/2025 for a diagnosis of scabies-NA, Staff I, was treated with permethrin cream on 11/19/2025 for a diagnosis of scabiesReview of the tracking list failed to identify that Resident ID #11 was also treated with permethrin cream on 10/21/2025 for a diagnosis of scabies.Review of an outside provider note dated 9/16/2025, revealed that NA, Staff F, was diagnosed with scabies and was also treated with ivermectin (an oral medication prescribed to treat scabies) in conjunction with the permethrin cream listed on the tracker.During a surveyor interview with the DNS on 12/4/2025 at 11:51 AM, she (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | acknowledged that there were cases of scabies in September, October, and November of 2025, and that she did not report the cluster to the Rhode Island Department of Health, as she was unaware that a cluster would require notification to the Rhode Island Department of Health.3) Review of a facility document titled 8-STEP ROOM CLEANING PROCEDURE last revised on 2/11, states in part, .DAMP WIPE DISINFECTANT CLEANING: (Supplies needed: clean rag, disinfectant cleaner) using a clean rag that has been sprayed with germicidal cleaner, wipe doorknobs, over-bed tables, spots on walls, doors, windows, furniture, bed rails, etc.During the initial tour on 12/3/2025 a strong perfume like odor was identified by the survey team.During a surveyor observation of the house keeping cart on 12/4/2025 at 12:20 PM, with Housekeeper, Staff J, a purple lavender scented bottle of Fabuloso was revealed.During a surveyor interview immediately following the above-mentioned observation with Staff J, she revealed that she cleans the walls of the facility with Fabuloso.During a surveyor interview on 12/4/2025 at 12:46 PM, with the Maintenance Director, he revealed that the Fabuloso is used only for the walls.Review of the Fabuloso multipurpose cleaner failed to reveal evidence that the product is a disinfectant, as required, per the facility cleaning procedure.Review of the EPA approved disinfectant list failed to reveal evidence that Fabuloso is an approved disinfectant.During a surveyor interview on 12/5/2025 at 9:00 AM, with the DNS, she revealed that she would expect the facility to be cleaned with a disinfectant to prevent the spread of infectious diseases.During a surveyor interview on 12/5/2025 at 9:41 AM, with the Maintenance Director, he acknowledged that Fabuloso is not listed as a disinfectant, and he will remove the product from the units.4) According to the Infection Control Assessment and Response (ICAR) Tool for General Infection Prevention and Control (IPC) Across Settings.Wound Care Facilitator Guide, hand hygiene should be performed .before moving from work on a soiled body site to a clean body site on the same patient.Record review revealed Resident ID #5 was readmitted to the facility in June of 2025, with a diagnosis including, but not limited to, type 2 diabetes.Record review revealed a physician's order dated 12/2/2025, to cleanse the sacral (coccyx) wound with wound wash, apply silver sulfadiazine (a wound cream) to the open area, then apply calcium alginate dressing (N absorbent dressing which creates a gel like substance that maintains a moist wound environment).During a surveyor observation on 12/5/2025 at 9:08 AM, with Registered Nurse, Staff A, of Resident ID #5's wound care treatment revealed, Staff A, cleansed the resident's wound on his/her sacrum. She then applied silver sulfadiazine to the wound bed, followed by a square of calcium alginate over the wound and surrounding skin. She then applied a clean dressing over the site. Staff A failed to remove her soiled gloves and perform hand hygiene before moving from a soiled body site to a clean body site.During a surveyor interview with Staff A immediately following the above-mentioned observation, she acknowledged that she that she failed to change her gloves when moving from a soiled body site to a clean body siteDuring a surveyor interview with the Director of Nursing Services on 12/5/2025 at 9:27 AM, she revealed that she would expect Staff A to change her gloves and perform hand hygiene before moving from a soiled body site to a clean body site.5) Record review of the CDC document titled, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings, dated June 2021, version 1.1 states in part, .The key to preventing Legionnaires' disease is maintenance of the water systems in which Legionella may grow .Water stagnation: Encourages biofilm growth and reduces temperature and levels of disinfectant. Common issues that contribute to water stagnation include .reduced building occupancy .Stagnation can also occur when fixtures go unused, like a rarely used shower .Record review failed to reveal documentation that the facility was monitoring and flushing infrequently used fixtures including the laundry room eye wash station.During a surveyor interview with the Maintenance Director and the Administrator on 12/5/2025 at approximately 1:00 PM, they were unable to provide evidence that the facility implemented a flushing schedule to prevent water stagnation to maintain the facility's water quality. |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Keep residents' personal and medical records private and confidential.<br><br>Based on surveyor observation, clinical record review, and resident and staff interviews, the facility failed to ensure a resident's dignity was maintained relative to privacy of personal needs for 5 of 5 residents reviewed for the use of adult protective underwear, Resident ID #s 3, 16, 24, 28, and 31.Findings are as follows:Record review of a facility policy titled Resident Rights states in part, .As a resident you will be treated in a manner that promotes and enhances quality of life, ensuring dignity .Right to Privacy and Confidentiality: during treatment and care of one's personal needs .During a surveyor observation on 12/3/2025 at 12:17 PM, of the first-floor main hallway, signage was noted to be posted on the exterior door to the resident care supply closet. The signage revealed the following residents are to use pull-ups and all other residents are to use briefs: - Resident ID #3 - Resident ID #16 - Resident ID #24 - Resident ID #28 - Resident ID #31During a surveyor interview on 12/3/2025 at 10:49 AM, with Resident ID #28, s/he indicated that his/her privacy was important, and s/he would expect information and discussions related to his/her health conditions to be discrete. During a surveyor interview on 12/5/2025 at 9:22 AM, with the Director of Nursing Services, she acknowledged that signage related to residents' personal needs was posted in an area visible to visitors, staff and residents, the signage contained personal information regarding the use of adult protective underwear, and the posting did not maintain the residents' dignity. She further stated it was her expectation that such signage would be placed only in areas accessible to staff, to protect resident privacy. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>Based on clinical record review and staff interview, the facility failed to ensure psychotropic drug usage is based on the comprehensive assessment of a resident, and that residents who use psychotropic drugs (medications that are prescribed to affect behavior, mood, thoughts, or perception) receive gradual dose reductions (GDR) and behavioral interventions unless clinically contraindicated for 1 of 1 resident reviewed for a GDR, Resident ID #31.Findings are as follows:Review of a facility reported incident submitted to the Rhode Island Department of Health on 12/1/2025 revealed, Resident ID #31, the perpetrator, was trying to keep Resident ID #29 from speaking to a female resident and there was a physical altercation.Record review revealed Resident ID #31 was admitted to the facility in December of 2024 with diagnoses including, but not limited to, dementia with behavioral disturbance, mild neurocognitive disorder due to known physiological condition with behavioral disturbance, and major depressive disorder. The resident was discharged from the facility on 11/28/2025.Record review revealed the resident had an order for Quetiapine (a medication prescribed to treat major depressive disorder) dated, 6/17/2025 through 11/25/2025, 50 milligrams (mg) twice daily.Further record review revealed that the resident was receiving a GDR of the Quetiapine. On 11/25/2025 his/her orders were decreased as follows:-Quetiapine 25 mg once daily, with a start date of 11/25/2025.-Quetiapine 50 mg at bedtime, with a start date of 11/25/2025.Record review of the resident's care plan revealed a focus area for psychotropic drug usage. This care plan revealed interventions to monitor behaviors, mood, and side effects related to the medication, and to report any changes to the doctor.Review of the resident's record failed to reveal monitoring related to behaviors, mood changes or side effects related to psychotropic drug usage, or the current GDR schedule of Quetiapine.During a surveyor interview on 12/4/2025 at approximately 1:30 PM with the Director of Nursing Services, she could not provide evidence that the residents behavior and mood were being monitored related to the psychotropic usage and the GDR. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>Based on clinical record review and staff interview, the facility failed to provide appropriate treatment and services for 1 of 1 resident reviewed with a urostomy (a surgical procedure that creates an opening in the abdominal wall to allow urine to exit the body bypassing an injured or non functioning bladder), Resident ID #2.Findings are as follows:Record review revealed Resident ID #2 was readmitted to the facility in April of 2025, with a diagnosis including, but not limited to, malignant neoplasm of the bladder (bladder cancer).Record review of a Continuity of Care Consultation and Referral (COC), form dated 10/8/2025 revealed, the resident attended an appointment at the Cancer Institute and returned to the facility with recommendations and a prescription to start methenamine (an antibacterial medication primarily used to prevent and treat urinary tract infections (UTIs), 1 gram twice a day. Further review of the COC revealed to start methenamine for UTI prevention.Review of the resident's record failed to reveal evidence that the recommendation was reviewed with the Medical Director or that the medication was implemented.During a surveyor interview on 12/4/2025 at 8:29 AM, with Registered Nurse, Staff A, she acknowledged that the COC form and prescription for methenamine was received on 10/8/2025. Additionally, she acknowledged that the resident was not started on the methenamine.During a surveyor interview on 12/5/2025 at 10:10 AM, with the Medical Director, he revealed that if he was notified of the recommendation to start methenamine 1 gram twice a day for UTI prevention, he would have implemented the medication.During surveyor interviews with the Director of Nursing Services, on 12/4/2025 at 8:32 AM and 12/5/2025 at 1:40 PM, she was unable to provide evidence that Resident ID #2 was started on the methenamine for UTI prevention per the COC. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 415108 | A. Building<br>B. Wing | 12/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Harris Health Care Center North | 60 Eben Brown Lane<br>Central Falls, RI 02863 |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care or services that was trauma informed and/or culturally competent.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure that residents who are trauma survivors, receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents experiences, and preferences, in order to eliminate, or mitigate triggers that may cause re-traumatization of the resident for 2 of 3 resident reviewed with a history of trauma, Resident ID #s 3 and 16.Findings are as follows:Review of the facility's form titled PC [Primary Care]-PTSD [Post Traumatic Stress Disorder]-5 states in part, .The primary PC-PTSD-5 is a 5-item screen designed to identify individuals with probable PTSD .Review of a facility policy titled, Trauma Informed Care revealed in part, .A trauma screening assessment will be done on each resident by the social worker as part of the admission social history. When it is not practical or possible to interview the resident, information will be obtained from family members.when they are able and authorized to provide such information.The particular type and extent of the trauma (as best can be determined) will be incorporated when planning culturally competent, resident centered care with the purpose of avoiding re-traumatization.A trauma informed care plan including cultural preferences, will be developed as needed and the resident monitored accordingly.1) Resident ID #3 was readmitted to the facility in April of 2024, with diagnoses including, but not limited to, dementia with behavioral disturbance, and depression.Review of an undated Primary Care PTSD screen revealed Yes was circled, indicating that the resident had experienced an event that is especially frightening, horrible, or traumatic. It was documented on the form that the resident had experienced the Korean War, and in the month prior, had experienced nightmares, tried not to think about the events, and been on guard, watchful, or easily startled.During a surveyor interview on 12/4/2025 at approximately 10:00 AM, with the Social Worker designee, she acknowledged that the initial screen documents trauma and that it is not reflected in his/her care plan.2) Resident ID #16 was readmitted to the facility in January of 2019 with diagnoses including, but not limited to, alcohol dependence, major depressive disorder and mood disorder due to known physiological condition with depressive features.Record review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 4 out of 15, indicating the resident has severely impaired cognition.Review of an undated Primary Care PTSD Screen revealed yes was circled indicating that the resident had experienced an event that is especially frightening, horrible, or traumatic. It was documented on the form that the resident had experienced a roadside bomb which exploded during a drill in the Army.During a surveyor interview on 12/4/2025 at approximately 12:30 PM with the Social Worker Designee she revealed that the PTSD screen indicating the resident had experienced a roadside bomb was completed with the resident's family member. Additionally, she acknowledged that it is not reflected in his/her care plan.Review of the comprehensive care plans for the above-mentioned residents failed to include trauma informed care and interventions to eliminate or mitigate triggers that may cause re-traumatization of the residents.During a surveyor interview on 12/4/2025 at 2:16 PM, with the Director of Nursing Services, she could not provide evidence of trauma informed care plans in place for the above-mentioned residents.During a surveyor interview on 12/5/2025 at 10:07 AM, with the Psychiatric Nurse Practitioner, she indicated that she was unaware that the above-mentioned residents had a history of trauma. |

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| F 0710<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.<br><br>Based on clinical record review and staff interview, the facility failed to ensure the medical care of each resident is supervised by a physician for 1 of 1 resident reviewed following an admission from home, Resident ID #2.Findings are as follows:Record review revealed that Resident ID #2 was readmitted to the facility in April of 2025, with a diagnosis including, but not limited to, malignant neoplasm of the bladder (bladder cancer).Record review revealed the resident was a former resident of the facility. The resident was discharged home in December of 2024 and was readmitted in April of 2025.Review of the resident's medical record failed to reveal evidence of a written recommendation for admission to the facility, including admission orders, summary of care, medication regime, preadmission screening and a resident review for the April 2025 admission. Further review of the physician's orders revealed an unsigned order to admit the resident to the facility for a prior admission in 2023. Additionally, of the active physician orders for the resident, 26 of the resident's physician orders were not signed by a provider.During a surveyor interview on 12/3/2025 at 1:38 PM, with the Social Worker designee and the Director of Nursing Services (DNS), they revealed that the resident was readmitted from home and was unsure of what documents the resident came to the facility with.During a surveyor interview on 12/4/2025 at 8:25 AM, with the Social Worker designee, she revealed that she completes the admission screening for new residents. She revealed that she doesn't believe that the resident came to the facility with any paperwork, rather that they reinstated the residents' orders from December of 2024 for the admission in April of 2025. She revealed that the resident's representative stated that there were no medication changes in the community. During a surveyor interview on 12/5/2025 at 8:54 AM, with the DNS, she was unable to provide evidence that Resident #2 had written physician approval for admission, such as a hospital transfer summary or other physician documentation. She also confirmed there was no active or signed physician order admitting the resident in 2025. In addition, she acknowledged that 26 physician orders were unsigned and could not provide evidence that the resident was readmitted with a new Preadmission Screening and Resident Review for the April admission. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure that the resident's drug regimen is free from unnecessary drugs for 1 of 1 resident reviewed for antibiotics, Resident ID #7. Findings are as follows:Record review revealed the resident was readmitted to the facility in October of 2025 with a diagnosis including, but not limited to, cellulitis (a common bacterial skin infection) of the left upper limb. Record review of an acute care hospital Discharge summary dated [DATE] revealed, a physician's order for Amoxicillin-Clavulanate (an antibiotic prescribed to treat a wide range of bacterial infections, made up of two separate antibiotic's) 875-125 milligram (mg) tablet, twice a day, for seven days, from 10/4/2025 through 10/10/2025.Record review of the Medication Administration Record (MAR) for October 2025 revealed, an order for amoxicillin (an antibiotic used to treat simpler and common infections) 875 mg, twice a day, with a start date of 10/4/2025 and a discontinue date of 10/6/2025. Review of the October 2025 MAR revealed the resident received three doses of amoxicillin 875 mg from 10/5/2025 through 10/6/2025, instead of Amoxicillin-Clavulanate 875-125 mg, as ordered. Further record review of the October 2025 MAR revealed an order for Amoxicillin-Clavulanate 875-125 mg, twice a day, for seven days, with a start date of 10/6/2025 and a discontinue date of 10/27/2025. Additional review of the October 2025 MAR revealed the resident received 11 additional doses of Amoxicillin-Clavulanate 875-125 mg after 10/10/2025 on the following dates: - 10/11: two doses - 10/12: two doses - 10/13: one dose - 10/14: two doses - 10/17: one dose - 10/18: one dose - 10/19: one dose - 10/25: one dose - 10/26: one doseDuring a surveyor interview on 12/5/2025 at 12:12 PM with the Director of Nursing Services (DNS), she acknowledged the resident received three doses of the wrong antibiotic from 10/4/2025 through 10/6/2025 which was amoxicillin 875 mg instead of Amoxicillin-Clavulanate 875-125 mg, as ordered. Additionally, the DNS acknowledged the resident received 11 doses of Amoxicillin-Clavulanate 875-125 mg after 10/10/2025 on the above-mentioned dates. During a surveyor interview on 12/5/2025 at 12:25 PM with the Medical Director, he acknowledged that he did not give an order to extend the Amoxicillin-Clavulanate beyond 10/10/2025. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure each resident's medication regimen is free from a medication error rate of 5% or greater. Based on 25 opportunities for errors observed during the medication administration task, there were 4 errors resulting in an error rate of 16% affecting Resident ID #s 2, 5, and 10. Findings are as follows:1) Record review revealed Resident ID #2 has a physician's order for Magnesium 200 milligram (MG) with instructions to administer 2 tablets, every day.During a surveyor observation during the medication administration task on 12/3/2025 at approximately 12:10 PM with Certified Medication Technician (CMT), Staff C, she was administered 1 tablet of Magnesium Oxide 400 MG, to ID #2.During a surveyor interview with Staff C, immediately following the above observation she acknowledged administering Magnesium Oxide instead of Magnesium as ordered stating, that's what I always give. 2a) Record review revealed Resident ID #5 has a physician's order for Lactulose 10 Gram (GM) packet with instructions to administer 30 milliliters (mL), 3 times a day.During a surveyor observation during the medication administration task on 12/3/2025 at approximately 12:20 PM with Staff C, she administered liquid Lactulose 10 GM/15 mL, measuring out 30 mL to equal 20 GM of lactulose, to ID #5During a surveyor interview with Staff C immediately following the above observation, when the surveyor asked whether the resident was supposed to receive 10 gm, as ordered, or the 20 gm that was being administered, she responded, I don't know.2b) During a surveyor observation during the medication administration task on 12/4/2025 at approximately 8:10 AM with CMT, Staff D, she was observed to prepare liquid Lactulose 10 GM/15 mL, 30 mL, to equal 20 GM, for ID #5.During a surveyor interview with Staff D, when she was prepared to administer the medication, she was asked why she was administering 20 GM instead of the 10 GM packet, as the order indicated, she stated, I follow the instructions that say to give 30 mL. Additionally, she acknowledged that the order indicates to give a 10 GM packet, and she stated all they have is the liquid, she was unsure if it should be 10 GM or 20 GM.3) Record review revealed Resident ID #10 has a physician's order for Acetaminophen liquid 500 MG/15 mL, with instructions to administer 1000 MG.During a surveyor observation during the medication administration task on 12/3/2025 at approximately 12:25 PM with CMT, Staff C, she was administered 1000 MG of Acetaminophen as crushed tablets, instead of the liquid form that was ordered.During a surveyor interview with Staff C, at the time of medication preparation she acknowledged that she was going to administer crushed tablets and not the liquid that was ordered. Additionally, she revealed that the facility does not have liquid Acetaminophen. Staff C administered the crushed tablets instead of the liquid, as ordered, although it was brought to her attention by the surveyor.During a surveyor interview on 12/4/2025 at approximately 9:20 AM, with the Director of Nursing Services, she acknowledged that the above medications were not administered as ordered. Additionally, she revealed that she would expect staff to get clarification from a doctor if the order is unclear or the medication form is unavailable. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that residents are free from significant medication errors.<br><br>Based on clinical record review and staff interview, the facility failed to ensure residents are free from any significant medication errors for 1 of 1 resident reviewed with a hospital recommendation, Resident ID #1. Findings are as follows:Record review revealed the resident was admitted to the facility in October of 2025 with a diagnosis including, but not limited to, hypertension (high blood pressure). Record review of acute care hospital discharge orders, dated 10/9/2025 revealed, an order to discontinue Metoprolol XL (a long-acting form of medication taken daily to treat high blood pressure) 25 milligram (mg) daily and start Metoprolol Succinate (a long-acting form of medication taken daily to treat high blood pressure) 50 mg daily. Record review of a physician order with a start date of 10/9/2025 revealed an order for Metoprolol Tartrate (an immediate-release/short-acting form of medication taken at least twice a day to treat high blood pressure) 25 mg daily. Record review of the Medication Administration Record from October 9, 2025, through December 4, 2025, revealed the resident received Metoprolol Tartrate 25 mg daily instead of Metoprolol Succinate 50 mg, as ordered. During a surveyor interview on 12/4/2025 at 9:42 AM, with the Director of Nursing Services, she acknowledged the resident should have received Metoprolol Succinate 50 mg daily instead of Metoprolol Tartrate 25 mg daily and was unable to provide evidence why the order had not been changed.During a surveyor interview on 12/4/2025 at 9:49 AM, with the Medical Director, he was unable to provide evidence the resident received the Metoprolol Succinate 50 mg, as ordered. Additionally, he indicated that he had no recollection of changing the order from Metoprolol Succinate to Metoprolol Tartrate as indicated on the MAR and would expect the staff to follow the discharge orders as mentioned above. |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.<br><br>Based on surveyor observation, clinical record review, and staff interview, the facility failed to provide sufficient support personnel with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration the individual needs of 2 of 2 residents reviewed for modified diets, Resident ID #s 13 and 15, and to safely and effectively carry out the functions of the food and nutrition service for all residents. Findings are as follows:During the initial tour of the main kitchen on 12/3/2025 at approximately 8:40 AM, the Food Service Director (FSD) revealed that he works 7 days per week to provide all three meals to the residents, with an average work week of 60-65 hours per week. Additionally, he revealed that he receives some assistance from a Dietary Aid/Cook, Staff E. He further revealed that Staff E maintained a Food Handlers Certification, and not a Food Managers Certification, as required, to work independently, to safely and effectively carry out the functions of the food and nutrition services.Record review of a facility document titled Detailed Hours Overview revealed, Staff E had worked independently, performing all functions of food and nutritional services, on the following dates: - Monday 11/10/2025 - Tuesday 11/11/2025 - Wednesday 11/12/2025 - Thursday 11/13/2025 - Friday 11/14/2025 - Wednesday 11/19/2025 - Wednesday 11/26/2025During a surveyor interview with the FSD on 12/4/2025 at 11:23 AM he revealed that the facility currently had two residents that receive modified diets. He further revealed that the ground and puree textures were modified daily for each meal the residents received.Record review reveals Resident ID #13 was admitted to the facility in October of 2024 with diagnoses including, but not limited to, cerebral infarction (a stroke) and dysphasia (difficulty swallowing). Further record review revealed s/he has a physician's order for a modified diet of a puree texture with gravy on the side.Record review reveals Resident ID #15 was admitted to the facility in July of 2024 with diagnoses including, but not limited to, muscle weakness and the need for assistance. Further record review revealed s/he has a physician's order for a modified diet of a ground texture.During a surveyor interview on 12/5/2025 at 8:24 AM with the Administrator, he was unable to provide evidence that Staff E had the appropriate competencies and skills sets required to safely and effectively carry out the functions of the food and nutrition service independently. Additionally, he was unable to provide evidence that Staff E held a Food Manager's Certification, as required. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure that services provided meet professional standards of quality and practices relative to 1 of 1 resident observed during wound care, Resident ID #5.Findings are as follows:Record review revealed that Resident ID #5 was readmitted to the facility in June of 2025, with a diagnosis including, but not limited to, type 2 diabetes.Record review revealed a physician's order dated 12/2/2025 to cleanse the sacral (coccyx) wound with wound wash, apply silver sulfadiazine (a wound cream) to the open area, then apply calcium alginate dressing (an absorbent dressing which creates a gel like substance that maintains a moist wound environment. Correctly sizing the dressing helps effectively manage fluid, prevent damage to surrounding skin, and promote an optimal healing environment).Review of Resident ID #5's care plan, last revised on 6/17/2025, revealed that s/he has pressure ulcers or vascular wounds to the buttocks with interventions including, but not limited to, keep the skin clean and dry as possible, and minimize skin exposure to moisture.During a surveyor observation of Resident ID #5's wound care treatment on 12/5/2025 at 9:08 AM, with Registered Nurse, Staff A, revealed, Staff A applied a square of calcium alginate over the wound and surrounding skin and not directly in the base of the wound. Staff A failed to cut the wound dressing to fit to the size of the wound.Review of the package instructions for the calcium alginate utilized, revealed to apply the dressing to the wound and loosey fill the wound.During a surveyor interview with Staff A immediately following the above-mentioned observation, she acknowledged that she failed to cut the dressing to the size of the wound bed, as indicated.During a surveyor interview with the Director of Nursing Services on 12/5/2025 at 9:27 AM, she was unable to provide evidence that Staff A cut the calcium alginate to the size of the wound bed to keep the skin dry and minimize skin exposure to moisture, per the manufacturer's instructions and care plan. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on clinical record review and staff interview, the facility failed to provide appropriate treatment and services for 2 of 2 residents reviewed for a change in condition related to bleeding, Resident ID #s 5 and 16.Findings are as follows:1) Record review revealed Resident ID #5 was admitted to the facility in June of 2025 with diagnoses including, but not limited to, obstructive and reflux uropathy (when urine cannot flow through the urinary tract due to a blockage) and thrombocytopenia (a deficiency of platelets in the blood that causes bleeding).Record review of a progress note dated 11/24/2025 at 2:20 PM revealed, Resident ID #5 was noted to be bleeding from his/her genitalia, and a urology appointment should be scheduled.Record review failed to reveal evidence that the provider was notified, that a treatment was initiated, or that a urology consult was scheduled for Resident ID #5.During a surveyor interview on 12/5/2025 at 10:11 AM with the Medical Director, he revealed that he does not remember if he was notified about Resident ID #5's bleeding and would expect the resident to be scheduled for a urology appointment after the bleeding was identified on 11/24/2025.During a surveyor interview on 12/5/2025 at 9:04 AM, with the Director of Nursing Services (DNS), she was unable to provide evidence that Resident ID #5's bleeding was reported to a provider, or a urology appointment was scheduled or obtained. 2) Record review revealed Resident ID #16 was readmitted to the facility in January of 2019 with diagnoses including, but not limited to, dementia with behavioral disturbance, and a personal history of infectious and parasitic diseases.Record review of a progress note dated 11/9/2025 at 8:32 AM by Staff Nurse B revealed, she had been informed in report that the resident was having hematuria (blood in the urine), so a urine specimen had been obtained. It further revealed that there was no confirmation that the lab had picked up the specimen and there was no documentation on the labs electronic system regarding the urine specimen. Staff B called the lab and left a message to try and confirm the specimen was picked up and then called the Medical Director to obtain further information regarding the resident's lab work. Additionally, the note revealed, the patient was observed to have blood on his/her brief and states, .Placing a nurse order.to monitor vital signs until further orders obtained by provider.Further record review of the progress notes failed to reveal evidence that the lab or the Medical Director returned Staff B's telephone call, or that any orders were provided. Additionally, the progress notes failed to reveal further documentation regarding the status of the resident's bleeding.Record review of the physician's orders failed to reveal an order to obtain a urine specimen for the resident on or around 11/9/2025.Record review of the Treatment Administration Record from 11/6/2025 through 12/5/2025 revealed, the nurses were monitoring every shift for bruising or bleeding because the resident was taking Aspirin. However, on the following dates the word monitoring was documented and there was no indication if the resident was bleeding or not: 11/9, 11/14, 11/24, 11/25, 11/29, 12/3, and 12/4/2025. On all other shifts during this period no or none was documented.During a surveyor interview on 12/4/2025 at 10:56 AM, with Registered Nurse (RN), Staff A, she revealed that the resident showed signs of bleeding at one time but stated that s/he hasn't had any bleeding lately and currently has no signs of a urinary tract infection. Staff A was unable to provide evidence of a physician's order to obtain a urine specimen. Additionally, she went on the labs electronic system and found no evidence of urine culture results. She stated that if the resident was showing signs of bleeding the doctor should be notified and orders should be obtained, but she was unable to provide evidence that this occurred.During a surveyor interview on 12/4/2025 at 12:57 PM, with RN, Staff B, she revealed that when she started her shift on 11/9/2025 she was notified in report that the resident presented with hematuria the previous day and that a urine specimen was obtained. She indicated that she contacted the physician regarding labs, but she did not speak to him regarding the urine specimen because she believed it had already been obtained.During a surveyor interview on 12/4/2025 at 11:09 AM, with the Medical Director, he stated that if a resident had hematuria, he would have ordered a urine specimen.During a surveyor interview on 12/4/2025 at 11:17 AM, with the<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Director of Nursing Services, she could not provide evidence that the Medical Director was notified of the hematuria, an order was obtained, or a urine culture was collected for the resident. She further acknowledged the lack of documentation regarding the patient's bleeding. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 415108 | A. Building<br>B. Wing | 12/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Harris Health Care Center North | 60 Eben Brown Lane<br>Central Falls, RI 02863 |

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

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|---|---|
| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>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 1 resident reviewed for oxygen therapy, Resident ID #1. Findings are as follows:Record review of a facility's policy dated 11/13/2015 and titled, Oxygen Administration states in part, .Maintenance of Equipment.cannulas [a tubing that delivers oxygen through the nose] are to be changed as needed and at least weekly.Documentation.Document the date, time, amount, and method of oxygen administration.Ensure that there is evidence of oxygen administration for the duration of the therapy.Record review revealed the resident was admitted to the facility in October of 2025 with diagnoses including, but not limited to, chronic obstructive pulmonary disease (a progressive lung disease) and tracheostomy status (a patient having a surgically created opening in their windpipe for breathing). Review of a physician's order dated 10/9/2025 revealed an order for oxygen 2-4 liters (L) as needed. During surveyor observations on the following dates and times, the resident was observed receiving 2L of oxygen via a nasal cannula which was discolored throughout, and the tubing was not dated:-12/3/2025 at 11:31 AM and at 12:11 PM-12/4/2025 at 9:35 AM, 11:26 AM, and at 11:54 AMRecord review of the Treatment Administration Record for October 9, 2025, through December 4, 2025, and the nursing progress notes, failed to reveal evidence of the date, time, and amount of oxygen the resident was receiving, as per the facility's policy. Additional clinical record review failed to reveal evidence of a physician's order to change the oxygen tubing weekly.During a surveyor interview on 12/4/2025 at 12:08 PM with the Director of Nursing Services, she indicated that she would expect the oxygen tubing to be changed weekly and acknowledged there was not an order in place to change the tubing. Additionally, she was unable to provide evidence the staff were documenting the date, time, amount, and method of oxygen administration, as required. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on surveyor observation and staff interview, the facility failed to store drugs and biologicals in accordance with currently accepted professional principles relative to 1 of 2 medication carts observed and 1 resident observed with medication at the bedside, Resident ID #1. Findings are as follows:Review of a facility policy titled Storage and Expiration Dating of Medications and Biologicals with a revision date of 6/30/2025, states in part, .Facility should ensure all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors.Once any medication or biological packed is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications.1) Surveyor observation of the medication cart on 12/4/2025 at 8:01 AM, in the presence of Registered Nurse, Staff A revealed, a Lantus insulin (a medication used to treat diabetes) pen opened and dated 10/1. Manufacturer instructions indicate to discard the insulin pen 28 days after opening. During a surveyor interview immediately following the above-mentioned observation, Staff A acknowledged the insulin should have been discarded.2) During surveyor observations on 12/3/2025 at 11:43 AM and on 12/4/2025 at 8:39 AM, of Resident ID #1's bedside table revealed, a Furoate/Vilanterol Ellipta 100 microgram (mcg)/25 mcg inhaler (a prescription medication used to help control symptoms of asthma and improve lung function). During an additional surveyor observation on 12/4/2025 at 8:40 AM of Resident ID #'s 1 bedside table in the presence of Staff A revealed a Furoate/Vilanterol Ellipta 100 mcg/2 mcg inhaler. During a surveyor interview with Staff A immediately following the above-mentioned observation, she acknowledged the inhaler was on the resident's bedside table and indicated that it should not have been stored there. During surveyor interviews on 12/4/2025 at 8:42 AM and at 9:20 AM with the Director of Nursing Services (DNS), she indicated that the inhaler should not have been stored on the resident's bedside table. Additionally, the DNS acknowledged the insulin pen was stored in the medication cart and dated 10/1. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Based on clinical record review and staff interview, the facility continues to fail to maintain complete and accurately documented medical records for 1 of 3 residents reviewed for medication administration, Resident ID #1.Findings are as follows:Record review revealed Resident ID #1 was admitted to the facility in October of 2025 with diagnoses including, but not limited to, type 2 diabetes mellitus with diabetic neuropathy (nerve pain caused by high blood sugar levels), tracheostomy status, abnormalities of gait and mobility, and schizophrenia.Record review revealed the following physician's orders:Amantadine HCl (a medication prescribed to treat sudden, uncontrolled movements), 100 milligrams (mg), 1 tablet twice per day, dated 12/7/2025Divalproex (an anticonvulsant medication prescribed to treat seizures and symptoms of bipolar disorder), delayed release, 250 mg, 1 tablet once per day, dated 10/9/2025Divalproex, delayed release, 500 mg, 1 tablet once per day, dated 10/9/2025Eliquis (a blood thinner), 5 mg, 1 tablet twice per day, dated 10/9/2025Gabapentin (a medication prescribed to treat nerve pain), 600 mg, 1 tablet three times per day, dated 10/9/2025Quetiapine (an antipsychotic medication), 400 mg, 1 tablet twice per day, dated 10/9/2025Review of the January 2026 Medication Administration Record (MAR) revealed that the resident was not administered the above-mentioned medications on 1/14/2026 for their scheduled 8:00 AM doses.During a surveyor interview via telephone with Certified Medication Technician, Staff C, on 1/15/2026 at 1:35 PM, she indicated that she administered the above medications to Resident ID #1 but did not sign them off as being administered in the resident's MAR. During a surveyor interview with the Director of Nursing Services on 1/15/2026 at 1:39 PM, she revealed that if medications were administered, she would expect them to be documented as such in the MAR. |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure the resident's medical record includes documentation that the resident either received the pneumococcal vaccination or did not receive the vaccination due to medical contraindications or refusal, for 2 of 5 residents reviewed, Resident ID #s 6 and 27 Additionally, the facility failed to have updated policies regarding immunizations.Findings are follows:According to the Centers for Disease Control and Prevention (CDC), pneumococcal vaccination for all adults 19 through [AGE] years old who have certain chronic medical conditions or 65 years or older who have only received PPSV23 (a type of pneumococcal conjugate vaccination), the PCV15 ( type of pneumococcal conjugate vaccine) or PCV20 (a type of pneumococcal conjugate vaccine) dose should be administered at least one year after the most recent PPSV23 vaccination. For adults 19 through [AGE] years old who have certain chronic medical indications who have only received PCV13 (a type of pneumococcal conjugate vaccine), give 1 dose of the PCV20 at least 1 year after PCV13 or give 1 dose of PPSV23 at least 8 weeks after PCV13. For adults 65 years or older who have only received PCV13, give PPSV23 or PCV20 as previously recommended. Together, with the patient, vaccine providers may choose to administer PCV20 or PCV21 to adults greater than or equal to [AGE] years old who have already received PCV13 (but not PCV15, PCV20, or PCV21) at any age and PPSV23 at or after the age of [AGE] years old.1a) Record review revealed Resident ID #6 was readmitted to the facility in August of 2023. Record review of the resident's immunization records revealed that the resident received his/her PPSV23 vaccine in November of 2020. Record review failed to reveal evidence that the resident was offered, received, or declined the PCV13, PCV15, PCV20, or PCV21 vaccine.1b) Record review revealed Resident ID #27 was admitted to the facility in March of 2023. Record review of the resident's immunization records failed to reveal evidence that the resident was offered, received, or declined the PCV13, PCV15, PPSV23, PCV20, or PCV21 vaccine.During a surveyor interview on 12/4/2025 at 11:49 AM, with the Director of Nursing Services (DNS), she was unable to provide evidence that Resident ID #s 6 and 27's medical records included documentation that indicates, at a minimum, if the residents either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.2) Review of a facility policy titled, Resident Vaccination (Flu and pneumonia) dated 3/2020 states in part, .Vaccinations are to be provided in accordance with the most recent ACIP (Advisory Council on Immunization Practices) guidelines for these vaccinations. As of 2019, ACIP has recommended the following pneumonia vaccination schedule (Also follow CDC Vaccination for Elders guidelines): ACIP recommends a routine single dose of PPSV23 for adults aged greater than or equal to 65 years who do not have an immunocompromising condition, cerebrospinal fluid leak or cochlear implant and who have not previously received PCV13. If a decision to administer PCV13 is made, PCV13 should be administered first followed by PPSV23 at least 1 year later .During a surveyor interview on 12/4/2025 at 11:50 AM with the DNS, she acknowledged that the policy that the facility is currently using is out of date and does not include the current guidelines for pneumococcal vaccinations. Additionally, the DNS revealed that the above immunization policy was not reviewed/revised annually, as required. |