STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415111	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Clare Home	309 Spring Street Newport, RI 02840

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **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 assessment accurately reflected the resident's status for 1 of 3 residents reviewed related to nutrition, Resident ID #32.Findings are as follows:Record review revealed the resident was admitted to the facility in June of 2022 with diagnoses including, but not limited to, bilateral knee osteoarthritis and type 2 diabetes mellitus.Record review of the resident's documented weights revealed s/he had a weight loss of 24.4 pounds (lbs.) (12.5%) within a month; from 195 lbs. on 12/11/2025 to 170.6 lbs. on 1/10/2026.Record review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], Section K, titled Swallowing/Nutritional Status, indicated the resident was not coded as experiencing a weight loss of 5% or more within the last month.Further record review revealed the resident had a weight loss of 40.6 pounds (20.5%) within the last 6 months; from 197.6 lbs. on 10/2/2025 to 157 lbs. on 4/1/2026.Record review of the Comprehensive MDS assessment dated [DATE], Section K, titled Swallowing/Nutritional Status, indicated that the resident was not coded as experiencing a weight loss of 10% or more in the last 6 months.During a surveyor interview on 5/13/2026 at 3:05 PM with the MDS Coordinator, she acknowledged that the MDS assessments mentioned above were inaccurate and did not reflect the resident's weight loss. During a surveyor interview on 5/14/2026 at 3:25 PM with the Director of Nursing Services, she indicated that she would expect the MDS assessments to accurately reflect the resident's weight loss, as required.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure that a person-centered comprehensive care plan was developed and implemented for 2 of 4 residents reviewed who utilize psychotropic medications, Resident ID #s 4 and 7, for 1 of 2 residents reviewed for pain management and for 1 of 1 resident reviewed related to bladder continence, Resident ID #9.Findings are as follows:1a. Record review revealed Resident ID #4 was admitted to the facility in December of 2025 with diagnoses including, but not limited to, major depressive disorder and generalized anxiety disorder.Record review revealed physician's orders for Sertraline (a medication prescribed to treat depression) 100 milligrams (mg) in the evening and Buspirone (a medication prescribed to treat anxiety) 10 mg daily. Record review of the care plan for depression and anxiety revealed interventions including, but not limited to, monitor and document for effectiveness and possible side effects of the above-mentioned medications every shift, and to monitor, document, and report changes in behavior, mood, and/or cognition.Record review failed to reveal evidence that the resident was being monitored every shift for effectiveness and possible side effects of the above-mentioned medications. Additionally, the record failed to reveal evidence that nurses are monitoring and documenting changes in the resident's mood, behavior, and/or cognition.1b. Record review revealed Resident ID #7 was admitted to the facility in July of 2024 with diagnoses including, but not limited to, major depressive disorder and post-traumatic stress disorder.Record review revealed a physician's order dated 9/4/2024 for Sertraline 75 mg in the morning for depression.Record review of the care plan dated 8/2/2024 for anti-depressant medication use revealed interventions including, but not limited to, monitor and document for the effectiveness and possible side effects of Sertraline every shift and to monitor, document, and report changes in behavior, mood, and/or cognition.Record review failed to reveal evidence that the resident was being monitored every shift for effectiveness and possible side effects of the sertraline. Additionally, the record failed to reveal evidence that nurses are monitoring and documenting changes in the resident's mood, behavior, and/or cognition.During a surveyor interview on 5/14/2026 at 12:09 PM with the Director of Nursing Services (DNS), she revealed that there should be specific orders for monitoring for the effectiveness and possible side effects of the above-mentioned medications, as well as specific orders to monitor for the resident's mood and behavior.2a. Record review revealed Resident ID #9 was admitted to the facility in March of 2026 with a diagnosis including, but not limited to, chronic pain.Record review of the physician's orders revealed the following medication orders for pain:-3/14/2026 Gabapentin 600 mg two times a day-3/13/2026 Acetaminophen 325 MG, give 2 tablets by mouth every 6 hours as needed, not to exceed 3 grams in 24 hours-3/17/2026 Oxycodone/Acetaminophen 10-325 MG, give 1 tablet by mouth three times a dayRecord review of the care plan dated 3/20/2026 revealed the resident has chronic pain and receives pain medication therapy. Interventions include, but are not limited to, administering analgesic medications as ordered and to monitor and document the effectiveness and side effects of the medication every shift.Record review failed to reveal evidence that the effectiveness and possible side effects of the pain medications were being monitored and documented every shift.During a surveyor interview on 5/14/2026 at 12:09 PM with the DNS, she was unable to provide evidence that the medication effectiveness and possible side effects of the medications were being monitored every shift.2b. Record review of Resident ID #9's Bowel and Bladder Program Screener, completed upon his/her admission, revealed s/he always voids appropriately without incontinence.Record review of Resident ID #9's point of care documentation revealed s/he was documented as continent of urine for 24 of 25 opportunities from 3/14/2026 through 3/24/2026. Further review revealed that from 3/25/2026 through 5/14/2026, s/he was documented to be incontinent of urine for 38 of 111 opportunities.Record review of the admission Minimum Data Set assessment dated [DATE] revealed (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	s/he was occasionally incontinent of urine and failed to have documentation that a trial toileting program had been attempted to improve or restore his/her continence.During a surveyor interview on 5/14/2026 at 11:55 AM with Nursing Assistant, Staff D, she revealed that Resident ID #9 is usually continent of urine but had an incontinent episode today.During a surveyor interview on 5/14/2026 at 11:56 AM with Resident ID #9 revealed that s/he can walk to the bathroom, but needs assistance with putting his/her brief up and down, and to wipe him/herself after toileting.During a surveyor interview on 5/14/2026 at approximately 12:00 PM with the DNS, she revealed that Resident ID #9 is not on a toileting program. She acknowledged that the the care plan failed to be developed and implemented to address the resident's bladder status.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, relative to 1 of 1 resident observed with a with a wound dressing applied without a physician's order, and for 1 of 4 residents reviewed with a physician's order for weekly weights that were not obtained, Resident ID #32.Findings are as follows:According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states in part, The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe that the orders are in error or would harm the clients.Record review for Resident ID #32 revealed s/he was admitted to the facility in June of 2022 with diagnoses including, but not limited to, type 2 diabetes mellitus (DM) with hyperglycemia (inadequate insulin production resulting in elevated blood glucose levels), and a skin picking disorder. 1a. During a surveyor observation of the resident on 5/14/2026 at 11:30 AM in the presence of Registered Nurse, Staff A, revealed a bordered gauze dressing (a type of wound dressing with a central absorbent pad and an adhesive border) dated 5/13, to the resident's right lower extremity. When Staff A removed the bordered gauze, a xeroform (a non-adherent gauze impregnated with petroleum and a bacterial protectant) dressing was observed covering a skin tear. Staff A acknowledged that the resident did not have a treatment order in place for the observed wound.During a surveyor interview on 5/14/2026 at 12:09 PM with the Director of Nursing Services, she was unable to provide evidence of a treatment order for the above-mentioned wound and would expect staff to obtain a physician's order for a wound treatment.1b. Further record review for Resident ID #32 revealed a physician's order dated 2/15/2026 to obtain weekly weights to start on 2/22/2026. Record review of a care plan dated 5/22/2024 identified nutrition as a focus area, with interventions including, but not limited to obtaining and monitoring weights as ordered. Review of the documented weights revealed the following:172.8 lbs. on 1/19/2026169.2 lbs. on 1/27/2026166.4 lbs. on 2/2/2026157.8 lbs. on 2/28/2026160.2 lbs. on 3/1/2026155.2 lbs. on 3/12/2026154.2 lbs. on 3/19/2026156.0 lbs. on 3/26/2026157.0 lbs. on 4/1/2026155.8 lbs. on 4/16/2026157.2 lbs. on 5/1/2026Record review failed to reveal evidence that weekly weights were obtained on 2/22/2026, 4/9/2026, 4/23/2026, and 5/7/2026, as ordered. During a surveyor interview on 5/13/2026 at 12:46 PM with Registered Dietitian, Staff C, she acknowledged that weekly weights were not obtained as ordered and that she does not verify whether ordered weights are obtained.During a surveyor interview on 5/13/2026 at 1:07 PM with Registered Nurse, Staff B, she acknowledged that the resident's weekly weights were not obtained as ordered and should have been.During a surveyor interview on 5/13/2026 at 3:42 PM with the Director of Nursing Services, she was unable to provide evidence that the resident's weekly weights were obtained as ordered.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to provide necessary treatment and services, consistent with professional standards of practice, to promote wound healing and prevent new ulcers from developing for 1 of 1 resident reviewed with pressure ulcers (a localized injury to the skin and/or underlying skin usually over a boney prominence), Resident ID #32. Specifically, the facility failed to obtain and implement timely treatment orders, failed to complete comprehensive weekly wound assessments, failed to ensure accurate documentation, and failed to ensure pressure-relieving equipment was properly set and monitored for Resident ID #32. These failures resulted in the worsening of the resident's skin condition, including the development of additional pressure injuries, deep tissue injuries, and progression of a sacral wound to an unstageable necrotic ulcer. Findings are as follows: According to the facility's undated policy titled, Wound Care states the following, The purpose of this procedure is to provide guidelines for the care of wounds, to promote healing .Verify that there is a physician's order for this procedure. Review the resident's care plan to assess for any special needs of the resident .Documentation The following information should be recorded in the resident's medical record .All assessment data (ie., wound bed color, size, drainage, etc.) obtained when inspecting the wound . Record review revealed the resident was admitted to the facility in June of 2022 with diagnoses including, but not limited to, type 2 diabetes mellitus (DM) with hyperglycemia (inadequate insulin production resulting in elevated blood glucose levels), excoriation (skin-picking) disorder. Record review of an Annual Minimum Data Set Assessment, dated 4/18/2026 revealed the resident has three unhealed Stage 2 pressure ulcers (partial loss of skin thickness presenting as a shallow open ulcer with a red-pink wound bed). Further record review revealed s/he has a Brief Interview for Mental Status score of 14 out of 15, indicating s/he is cognitively intact.Record review revealed a care plan revised in August of 2025 addressing the impaired skin integrity due to impaired mobility, incontinence, DM, peripheral vascular disease, chronic kidney disease, and pruritus (irritated skin sensation causing you to scratch) with a history of self-inflicted scratches. Interventions include, but are not limited to, an air mattress to the bed as ordered, apply lotions and medications as ordered, and a full skin inspection will be completed weekly by the nurse and as needed. Additionally, the record failed to reveal evidence that a care plan was developed and implemented for the resident's actual pressure ulcers. 1. Review of the Weekly Skin and Wound Assessment dated 4/7/2026, indicated the resident developed the following Stage 2 Pressure Ulcers:Right hip, 3 x 1.4 x 0 centimeters (cm)Right buttock, 0.8 x 1.4 x 0Right buttock, 0.6 x 0.8 x 0An additional sacral wound measuring 1.8 x 4.6 x 0 cm was also identified; however, the wound stage (refers to the classification of the extent and severity of a pressure ulcer) was not documented.The assessment failed to include required wound descriptions, including wound bed characteristics, wound edges, surrounding tissue, the presence and type of exudate (drainage), odor, undermining or tunneling (wound complications where tissue damage extends beyond the visible surface opening), and pain. Record review revealed the following physician's orders implemented for wound treatments:4/2/2026, wash buttocks (bilateral) using normal saline (a salt/water solution used in wound care), pat dry and apply Triad cream (a topical wound treatment prescribed to treat various wounds) to the excoriated areas (the order was discontinued on 5/12/2026). 4/7/2026, cleanse the right upper buttock, right lower buttock, right hip, and sacrum wounds with normal saline, pat dry, apply Triad cream to the wound bed, skin prep the periwound (skin surrounding a wound) and cover each wound with a bordered foam dressing every day and prn (as needed). Review of the Weekly Skin and Wound Assessment dated 5/4/2026 revealed the resident developed an additional Stage 2 pressure ulcer to the left inner thigh measuring 1 x 2.2 x 0.1 cm. Record review failed to reveal evidence that treatment orders were initiated for this wound after its identification.Record review failed to reveal evidence that a wound treatment was initiated after the wound was identified on (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/4/2026, to prevent the resident's left inner thigh pressure ulcer from worsening.Further record review revealed an additional Weekly Skin and Wound Assessment dated 5/11/2026 that identified two right inner thigh Stage 2 pressure ulcers with measurements of 2 x 1 cm (missing depth) and 1.5 x 1 x 0.1 cm.Record review failed to reveal evidence that any wound treatments were implemented after the wounds were identified on 5/11/2026, to prevent the resident's left inner thigh pressure ulcer from worsening.During a surveyor interview on 5/14/2026 at 12:53 PM with the Director of Nursing Services (DNS) she acknowledged that treatment orders had not been implemented for the resident's right and left inner thigh pressure ulcers. 2. Record review of the following documents titled Weekly Skin and Wound Assessment revealed a consistent failure to provide evidence that the required descriptions for the resident's pressure ulcers were documented including; the wound stage, complete measurements, type of exudate, wound bed characteristics, wound edges, surrounding skin tissue, the presence of odor, the presence and extent of undermining or tunneling, and the presence of pain:- Review of the weekly wound assessment, dated 4/20/2026 revealed that a Stage 2 pressure ulcer was identified on the resident's left buttock with documentation of only a wound measurement, 1.8 x 1.8 x 0.1 cm. The assessment failed to provide evidence of the required descriptions for the Stage 2 pressure ulcer as stated above. - Review of the weekly wound assessment, dated 4/27/2026 continued to document the left buttock Stage 2 pressure ulcer with only a wound measurement, 1.7 x 1.7 x 0.2 cm. The assessment failed to provide evidence of the required descriptions for the Stage 2 pressure ulcers as stated above.- Review of the weekly wound assessment, dated 5/4/2026 revealed the resident's skin worsened as s/he had the following Stage 2 pressure ulcers: Left buttocks ulcers measuring 4 x 1.5 x 0.1 cm and 0.6 x 1 x 0.1 cmRight outer thigh ulcer measuring 1 x1 x 0.1 cmLeft inner thigh measuring 1 x 2.2 x 0.1 cmAdditionally, the 5/4/2026 assessment failed to provide evidence of the required descriptions for each Stage 2 pressure ulcer, including the presence of exudate, wound bed characteristics, wound edges, surrounding tissue description, the presence of odor, the presence and extent of undermining or tunneling, and the presence of pain.- Review of the weekly skin and wound assessment dated [DATE], revealed that the resident had the following pressure ulcers:Right outer hip measuring 1 x 1 cm (missing depth)Right inner thigh wounds measuring 3.5 x 1 cm and 2 x 1 cm (both missing depth)Sacral wounds measuring 1.5 x 1 x 0.1 cm. and 4 x 4 x 0.3 cmAdditionally, the 5/11/2026 assessment failed to include the required descriptions for each pressure ulcer. Further review of the assessment revealed no evidence that the resident's Stage 2 pressure ulcers on the left buttock and left inner thigh were assessed. In addition, there was no documentation that either pressure ulcers had healed. During a surveyor interview on 5/14/2026 at 12:53 PM with the DNS she was unable to provide evidence that the weekly wound assessments were completed with the required descriptions for each of the resident's pressure ulcers as mentioned above.Additional record review revealed a Wound Consult was ordered to have the contracted Wound Physician complete an evaluation of the resident's wounds on 5/18/2026. Record review of the Wound Physician's report dated 5/18/2026 revealed the following pressure ulcers that were identified:A new deep tissue injury (purple or maroon area of discolored intact skin due to damage of underlying soft tissue) to his/her left 5th toe measuring, 1.5 x 1.2 x 0.0 cm, without odor or exudate, and the periwound noted as unhealthy and unstable. A new deep tissue injury to his/her left outer foot, measuring 4.0 x 2.5 x 0.0 cm, without odor or exudate and the periwound noted as unhealthy and unstable. Sacral wound, an unstageable ulcer (full thickness tissue damage where the base of the wound is completely obscured by dead tissue (necrosis, eschar or slough) and the depth or severity of the wound is unable to be determined), measuring 4.0 x 3.5 cm (unable to determine depth), with a mild odor, unhealthy periwound, necrotic edges, moderate serosanguineous (thin watery pale pink or light red fluid) exudate, with 100 % necrotic tissue.Further review of the Wound Physician's report failed to include the previously identified pressure injuries to the resident's right and left buttocks, right hip, or left and right inner thighs. Additionally, the sacral wound is now an unstageable pressure ulcer with 100% necrotic tissue. During a surveyor interview on 5/21/2026 at 11:07AM with the DNS, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she revealed that the resident no longer has the previously identified Stage 2 pressure ulcers to his/her right and left buttocks, right and left inner thighs and the right hip. Additionally, she acknowledged that during the Wound Physician's evaluation, the resident was identified with 2 deep tissue ulcers and that his/her sacral pressure ulcer is now an unstageable pressure ulcer. 3. Record review revealed a physician's order dated 10/2/2025 for an air mattress to be applied to the bed and to check the pressure every shift for skin integrity.Record review revealed the resident's weight on 5/1/2026 was 157.2 pounds (lbs.).During a surveyor observation and interview on 5/11/2026 at 11:56 AM, revealed the resident's air mattress with the setting of 180. The resident was observed sitting in his/her recliner, and when asked about the comfort of his/her bed, s/he replied that the bed was really not that comfortable, indicating the air mattress setting may not have been adjusted to meet his/her individual comfort needs.Record review on 5/14/2026 at approximately 11:15 AM of the May 2026 Treatment Administration Record (TAR), revealed a physician's order to check the pressure setting of the air mattress every shift. Further review revealed that nursing staff documented the air mattress setting at 190, for 40 of 40 opportunities.During a surveyor observation on 5/14/2026 at 11:20 AM revealed the resident was sleeping on his/her air mattress with the setting on 180. Further observation failed to reveal evidence of 190 as a setting.During a surveyor observation and interview conducted on 5/14/2026 at 11:30 AM with Registered Nurse, Staff A, she stated that the air mattress setting should be adjusted according to the resident's weight. During the observation of the mattress settings, Staff A acknowledged that there was not a setting for 190 lbs., and that the mattress was currently set at 180, and that the appropriate setting should have been 150. Additionally, Staff A acknowledged that she documented the air mattress setting at 190 this morning on the TAR.During a surveyor interview on 5/14/2026 at 12:53 PM and 5/21/2026 at 11:07 AM with the DNS, she revealed that air mattress settings should be set according to the resident's weight, which would be at 150. She was unable to provide evidence that staff ensured the correct setting for the resident's air mattress. Additionally, the DNS acknowledged that the resident now has 2 deep tissue injuries and that his/her sacral pressure ulcer is now necrotic. During a surveyor interview on 5/21/2026 at 1:12 PM with the resident's provider, Registered Nurse Practitioner, Staff E, she revealed that she would expect the correct setting to be implemented and documented for the resident's air mattress. Additionally, she would expect that weekly skin assessments are consistently documented and that the Wound Physician is consulted for all pressure ulcers and treatment orders are obtained and implemented upon identifying any wounds. The facility failed to ensure the resident received appropriate assessment, monitoring, treatment, and prevention of pressure ulcers in accordance with facility policy and accepted standards of practice. Specifically, the facility failed to obtain and implement timely treatment orders, failed to complete comprehensive weekly wound assessments, failed to ensure accurate documentation, and failed to ensure pressure-relieving equipment was properly set and monitored. These failures resulted in the worsening of the resident's skin condition, including the development of additional pressure injuries, deep tissue injuries, and progression of a sacral wound to an unstageable necrotic ulcer.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on clinical record review and staff interview, the facility failed to maintain nutritional status, such as usual body weight, for 1 of 3 residents reviewed who experienced actual weight loss, Resident ID # 4. Findings are as follows:Record review of the facility's undated policy titled, Weight Assessment and Intervention, states in part, .Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation.nursing will immediately notify the dietitian.5. The threshold for significant unplanned and undesired weight loss will be based on the following criteria.a. 1 month - 5% weight loss is significant; greater than 5% is severe. b. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months - 10% weight loss is significant; greater than 7.5% is severe. Record review revealed Resident ID #4 was re-admitted to the facility in December of 2025 with diagnoses including, but not limited to, right hip fracture, hypothyroidism (abnormally low function of the thyroid), dysphagia (difficulty swallowing) and Parkinson's Disease (a progressive brain disorder that occurs when nerve cells of the brain die or become impaired).Record review revealed the following physician's orders:1/7/2026, Remeron (a medication prescribed to stimulate appetite) 15 milligrams (mg) daily4/21/2026, Prostat (a liquid protein supplement prescribed to provide additional protein) 30 milliliters (ml) daily4/21/2026, obtain weekly weights Record review of a care plan dated 12/23/2025 revealed the resident has a nutritional problem related to weight loss with a goal that s/he will maintain adequate nutritional status as evidenced by maintaining his/her weight.Record review revealed the following documented weights:112.5 pounds (lbs.) on 12/18/202599.0 lbs. on 4/3/2026 93.6 lbs. on 4/23/2026 88.4 lbs. on 5/4/2026Record review revealed the resident experienced the following weight loss:A severe weight loss of 12% (13.5 lbs.) from 12/18/2025 to 4/3/2026.A significant weight loss of 5.45% (5.4 lbs.) in less than 3 weeks from 4/3/2026 to 4/23/2026.A significant weight loss of 5.56% (5.2 lbs.) in less than 2 weeks from 4/23/2026 to 5/4/2026.Further record review failed to reveal evidence that weekly weights were obtained on 4/30 and 5/11/2026, as ordered. Additionally, the record failed to reveal evidence that a reweight was obtained within one day of the 4/3/2026, 4/23/2026 and 5/4/2026 weights, after the resident's weight revealed a 5% or more weight loss, per the facility policy. During a surveyor interview on 5/13/2026 at 12:32 PM with Registered Dietitian, Staff C, she acknowledged the resident experienced a significant weight loss and that the resident was not weighed weekly on 4/30 and 5/11/2026 after orders were implemented for weekly weights. She indicated that she does not verify if staff obtains weights as ordered, even for the residents who are being monitored for weight loss.During a surveyor interview on 5/13/2026 at 1:07 PM with the Registered Nurse, Staff B, she acknowledged that the resident had a significant weight loss and that s/he had not been weighed weekly on 4/30 and 5/11/2026 and should have been. Additionally, she revealed that she would obtain the resident's weight today. During a surveyor interview on 5/21/2026 at 1:58 PM with the resident's provider, she confirmed that she was aware of the resident's weight loss since January and had ordered for weekly weights to be obtained. She further revealed that she was unaware that staff failed to obtain the resident's weights weekly and that she would expect orders to be followed.During a surveyor interview on 5/13/2026 at 3:42 PM with the Director of Nursing Services, she acknowledged that the resident's weights were not obtained weekly as ordered and indicated that the expectation is that orders are followed.

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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 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 post cautionary and safety signs related to oxygen use for 2 of 3 residents reviewed receiving oxygen therapy, Resident ID #s 33 and 47.Findings are as follows:Record review of a policy titled Oxygen Administration states in part, .Steps in the procedure .Place an 'Oxygen in Use' sign on the outside of the room entrance door .1. Record review revealed Resident ID #33 was admitted to the facility in April of 2026 with a diagnosis including, but not limited to, acute respiratory failure with hypoxia (low levels of oxygen in the blood).Record review revealed a physician's order dated 4/20/2026 to titrate oxygen to maintain an oxygen saturation level (a measure of oxygen-carrying hemoglobin in the blood) greater than 92%.Surveyor observation of the resident's room failed to reveal evidence that a cautionary and safety sign was posted indicating oxygen was in use on the following dates and times:- 5/13/2026 at 9:00 AM- 5/14/2024 at 11:11 AM2. Record review revealed Resident ID #47 was admitted to the facility in December of 2025 with a diagnosis including, but not limited to, chronic obstructive pulmonary disease (COPD - a progress, irreversible lung disease that blocks airflow, making it difficult to breathe).Record review revealed a physician's order dated 12/20/2025 to administer oxygen continuously via nasal cannula (a flexible tube used to deliver supplemental oxygen directly into your nose) continuously to maintain oxygen saturation greater than 90%.Surveyor observations of the resident's room failed to reveal evidence that a cautionary and safety sign was posted indicating oxygen was in use on the following dates and times:- 5/13/2026 at approximately 9:00 AM- 5/14/2026 at 11:11 AMDuring a surveyor interview on 5/14/2026 at 11:15 AM with the Registered Nurse, Staff A, she acknowledged that both resident rooms failed to have a cautionary safety sign posted indicating oxygen was in use.During a surveyor interview on 5/14/2026 at approximately 11:30 AM with the Director of Nursing Services, she acknowledged that the facility failed to post cautionary safety signs indicating oxygen was in use for both residents.