STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415113	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tockwotton on the Waterfront	500 Waterfront Drive East Providence, RI 02914

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 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** 41729 46118 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that residents with pressure ulcers receive the necessary treatment and services, consistent with professional standards of practice, to promote healing for 1 of 1 resident reviewed with a pressure ulcer (skin and tissue injuries caused by constant pressure to a specific area of the body), Resident ID #250. Findings are as follows: Record review revealed the resident was admitted to the facility in February of 2025 with diagnoses including, but not limited to, dementia and abnormalities of mobility. Review of a Safe Patient Handling assessment dated [DATE] revealed the resident was dependent on staff for bed mobility. Review of a document titled Skin Integrity Events dated 2/5/2025 revealed an unstageable pressure ulcer (characterized by full-thickness tissue loss where the depth cannot be assessed due to the presence of dead tissue) was observed to the resident's right heel measuring 1.5 x [by] 2 x [depth] not measurable. Record review revealed the following physician's orders dated 2/5/2025: -No shoes until right heel blister resolved -Off load bilateral heels while in bed every shift During a surveyor observation on 2/10/2025 at 12:22 PM, the resident was in his/her wheelchair and wearing shoes on both feet. During surveyor observations on the following dates and times, the resident's heels were not offloaded and were resting directly on the mattress while lying in bed: -2/11/2025 at 9:36 AM (continued on next page)

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

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

Printed: 05/28/2025
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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415113	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tockwotton on the Waterfront	500 Waterfront Drive East Providence, RI 02914

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2/11/2025 at 3:17 PM -2/12/2025 at 11:26 AM -2/13/2025 at 8:53 AM During a surveyor interview on 2/13/2025 at 9:00 AM with Nursing Assistant, Staff A, she acknowledged that the resident's heels were not offloaded and they were resting directly on the mattress. She further acknowledged that the resident had a wound to his/her right heel. Additionally, she indicated that she was unaware if the resident's heels should be off loaded while in bed. During a surveyor interview on 2/13/2025 at 9:31 AM with Registered Nurse, Staff B, she indicated that the resident had a pressure ulcer to his/her right heel. She further indicated that the resident should not be wearing shoes until the pressure ulcer is healed and that his/her heels should be offloaded while in bed. Additionally, she acknowledged that the resident's heels were not offloaded while in bed at the time of the interview. During a surveyor interviews on 2/13/2025 at 9:55 AM and at 1:13 PM, with the Director of Nursing Services, she indicated that she would expect the resident's heels to be offloaded while in bed, as ordered.

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NAME OF PROVIDER OR SUPPLIER: Tockwotton on the Waterfront		STREET ADDRESS, CITY, STATE, ZIP CODE: 500 Waterfront Drive East Providence, RI 02914	

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 41729 46118 39496 Based on record review and staff interview, it has been determined that the facility failed to ensure that residents are free from any significant medication errors for 1 of 2 residents reviewed with a sliding scale insulin (Insulin dosage based on blood glucose reading), Resident ID #6, and 1 of 4 residents observed during the medication administration task, Resident ID #13. Findings are as follows: Review of a policy titled Administering Medications states in part, .Medications are administered in accordance with prescriber orders, including any required time frame .within one (1) hour of their prescribed time, unless otherwise specified . 1. Record review revealed Resident ID #6 was admitted to the facility in August of 2017 with a diagnosis including, but not limited to, diabetes mellitus. Record review of the physician's orders revealed the following: -11/4/2024- Novolog (insulin) 100 unit/milliliter(ml) administer 6 units three times a day, hold for blood glucose reading less than 65. -11/5/2024-Novolog (insulin) 100 unit/ml to be given three times daily before eating if: -the blood glucose reading is between 0-180- give no insulin -the blood glucose reading is between 181- 250- give two units of insulin -the blood glucose reading is between 251-300- give four units of insulin -the blood glucose reading is between 301-400- give eight units of insulin -the blood glucose reading is above 400 add ten units of insulin Record review of the Medication Administration Record (MAR) for February 2025 failed to reveal evidence that the resident received his/her Novolog as ordered on the following dates and times: -2/7/2025 during the 11:00 AM-1:00 PM dose- the blood glucose reading was documented as 212, and six units of insulin was documented as administered. This is a dosage four units higher than the dosage that should have been administered based on the resident's blood glucose reading. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Tockwotton on the Waterfront		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Waterfront Drive East Providence, RI 02914	

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2/7/2025 during the 4:30 PM- 6:00 PM dose- the blood glucose reading was documented as 94, and six units were documented as administered. This is a dosage six units higher than the dosage that should have been administered based on the resident's blood glucose reading. During a surveyor interview on 2/11/2025 at 3:14 PM with Registered Nurse, Staff C, she acknowledged that she was the nurse who documented that six units were given on 2/7/2025 during the 11:00 AM to 1:00 PM dose. She was unable to provide evidence that she had given the resident the correct dosage of Novolog insulin, as ordered, per the sliding scale. During a surveyor interview on 2/12/2025 at 1:19 PM, with the Director of Nursing Services (DNS), she could not provide evidence that the appropriate dose of Novolog was given based on the resident's blood glucose reading during the above-mentioned times. 2. Record review revealed Resident ID #13 was readmitted to the facility in November of 2024 with diagnoses including, but not limited to, dementia and hypertension. Record review revealed a physician's order dated 11/26/2024 for Amlodipine (a medication prescribed to treat high blood pressure), 5 milligrams (mg), every morning. Further review revealed the medication was scheduled to be administered before breakfast. Record review of the February 2025 MAR revealed the Amlodipine was charted as Late administration: Charted late on 2/10/2025 at 1:13 PM and on 2/11/2025 at 12:22 PM. During surveyor interviews on 2/11/2025 at 12:09 PM and on 2/12/2025 at 1:58 PM with Certified Medication Technician, Staff D, she indicated that the time charted on the MAR, is the time that she administered the medication. Additionally, she acknowledged the medication was administered late and not before breakfast, as ordered. During a surveyor interview on 2/13/2025 at 11:03 AM with the DNS she indicated that she would expect a medication that is scheduled to be administered prior to breakfast, to be administered prior to eating breakfast.

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NAME OF PROVIDER OR SUPPLIER Tockwotton on the Waterfront		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Waterfront Drive East Providence, RI 02914	

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 41729 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide and prepare food in a form designed to meet individual needs for 1 of 2 residents reviewed with a physician's order for thickened consistency fluids, Resident ID #301. Findings are as follows: Record review revealed the resident was admitted to the facility in February of 2025 with diagnoses including, but not limited to, dysphagia (difficulty in swallowing), pneumonia (infection of the lungs), and dementia. Record review revealed the following physician's orders: - 2/4/2025: Aspiration precaution (guidelines to prevent food or liquid from entering the airway while eating or drinking) - 2/6/2025: 120 milliliters (ml) of nectar (mildly thick) house supplement (nutritional supplement) once in the morning - 2/10/2025: Diet order for honey thick (moderately thick) liquids Record review of the Medication Administration Record (MAR) for February 2025 revealed the order for the house supplement nectar thick consistency was signed off by the staff on 2/11/2025 and 2/12/2025 as being administered, which is two days after the order had been changed to honey thick consistency on 2/10/2025. Record review failed to reveal evidence that the nectar thick house supplement order was changed on 2/10/2025 to reflect that the resident was now receiving honey thick consistency liquids, instead of the nectar thick consistency liquids that was previously ordered. During a surveyor observation of Certified Medication Technician, Staff E, on 2/13/2025 at 9:48 AM, she was observed measuring the nectar thick house supplement and proceeded to the resident's room to administered it when she was stopped by the surveyor. Staff E acknowledged the resident was on a honey thick consistency liquid diet. She further acknowledged that the house supplement that she had prepared to administer to the resident was a nectar thick consistency, and not honey thick consistency, as ordered. During a surveyor interview on 2/13/2025 at 10:26 AM with the Director of Nursing Services (DNS), she acknowledged that the resident's diet order had been changed from nectar thick consistency liquids to honey thick consistency liquids. Additionally, the DNS acknowledged that the house supplement order should have been changed to honey thick consistency instead of nectar as indicated on the MAR. During a surveyor interview on 2/13/2025 at 12:07 PM with the Medical Director, he indicated that he would have expected the resident to receive honey thick consistency liquids, as ordered. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tockwotton on the Waterfront	500 Waterfront Drive East Providence, RI 02914

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47939

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tockwotton on the Waterfront	500 Waterfront Drive East Providence, RI 02914

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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 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

41729

47939

Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to prepare, store, and distribute food according to professional standards of food service safety, relative to the main kitchen.

Findings are as follows:

1. Review of the Rhode Island Food Code, 2018 Edition, section 3-501.17 states in part, .(B) .refrigerated, ready-to-eat time/temperature control for safety food .shall be clearly marked, at the time the original container is opened in a food establishment .and: (1) the day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date .

During the initial tour of the main kitchen on 2/10/2025 at approximately 8:30 AM of the reach in refrigerator unit 4 was observed with the following:

-one 32 ounce jar of Sysco capers with an open date of 1/4/2025 and a use by date of 2/4/2025.

-one jar of pepperoncini peppers with an open date of 12/25/2025 and a use by date of 1/25/2025.

-six Styrofoam containers containing a white food substance which were unlabeled, without identification of the contents, a preparation date or a use by date.

During a surveyor interview at the time of the above observation with the Executive Chef, he indicated that the capers and pepperoncini peppers should have been discarded and the Styrofoam containers should have been labeled with the contents, preparation date and a use by date.

Additional observations during the initial tour of the main kitchen, in the presence of the Dietary Manger, of the reach in refrigerator unit 1 was observed with the following:

-one squeeze bottle of 32 ounce red wine vinaigrette with an open date of 12/29/2024 and a use by date of 1/29/2025.

-one squeeze bottle of 24 ounce ranch dressing with an open date of 12/12/2024 and a use by date of 1/12/2025.

During a surveyor interview with the Dietary Manager immediately following the above observations he indicated that the above-mentioned items should have been discarded.

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Tockwotton on the Waterfront	500 Waterfront Drive East Providence, RI 02914

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Record review of the Rhode Island Food Code, 2018 Edition, section 4-601.11 states in part, .(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 2/10/2025 at approximately 8:30 AM, in the presence of the Executive Chef, the following was observed: -The walk-in refrigerator's floor had a moderate amount of red liquid pooling below a box which contained a partially opened bag of chicken. -The ceiling of the walk-in freezer had icicles hanging down and accumulating ice on a food storage rack below. During a surveyor interview with the Executive Chef, at the time of the above observations he acknowledged the pooling of the red substance in the walk-in refrigerator and indicated it was blood from the box of chicken. Additionally, he acknowledged the accumulation of icicles in the freezer. During a subsequent observation of the main kitchen on 2/12/2025 at 11:50 AM, two days after the above mentioned observations were brought to the facility's attention, the following was observed: -the walk-in refrigerator floor was observed with a moderate of coagulated red liquid on the floor. -the ceiling of the walk-in freezer had icicles hanging down. -one box of spanakopita (Greek spinich pie) with an accumulation of ice directly under the frozen drips on the ceiling. During a subsequent surveyor interview on 2/12/2025 with the Dietary Manager at the time of the above observations, he acknowledged that walk-in refrigerator had a coagulated red liquid on the floor. He indicated the floor should have been cleaned. During a surveyor observation and simultaneous interview on 2/12/2025 at 12:36 PM, with the Administrator he acknowledged the build up of ice on the walk-in freezer ceiling and on the box of spanakopita.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 41729 39496 Based on record review and staff interview, it has been determined that the facility failed to ensure that medical records are accurately documented for 1 of 2 residents reviewed for sliding scale insulin (Insulin dosage based on blood glucose reading), Resident ID #6, and for 1 of 4 residents observed during the medication administration task, Resident ID #13. Findings are as follows: 1. Record review revealed Resident ID #6 was admitted to the facility in August of 2017 with a diagnosis including, but not limited to, diabetes mellitus. Record review revealed the following physician's orders dated 11/5/2024: -Novolog (insulin) 100 units/milliliters (u/ml) to be given three times daily before eating if: -the blood glucose reading is between 0-180- give no insulin -the blood glucose reading is between 181- 250- give two units of insulin -the blood glucose reading is between 251-300- give four units of insulin -the blood glucose reading is between 301-400- give eight units of insulin -the blood glucose reading is above 400- add ten units of insulin Record review of the February 2025 Medication Administration Record (MAR) failed to reveal evidence that the resident received his/her Novolog as ordered on 2/7/2025 for the 11:00 AM-1:00 PM dose. The blood glucose reading was documented as 212, and six units of insulin was documented as administered. This dosage is four units higher than the dosage that should have been administered based on the sliding scale. During a surveyor interview on 2/11/2025 at 3:14 PM with Registered Nurse, Staff C, she acknowledged that she was the nurse who documented that six units were administered on 2/7/2025 for the 11:00 AM to 1:00 PM dose. During a surveyor interview on 2/12/2025 at 1:19 PM, with the Director of Nursing Services (DNS), she reviewed the MAR in the presence of the surveyor and revealed that on 2/7/2025 for the 11:00 AM to 1:00 PM dose, 2 units of Novolog were documented as being administered. This surveyor showed the MAR to the DNS that she saved on 2/11/2025, and the DNS acknowledged that six units of insulin was documented as being administered on 2/7/2025 for the 11:00 AM to 1:00 PM dose. The DNS indicated that Staff C must have gone back and edited the MAR to reflect the dosage of the two units. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Tockwotton on the Waterfront		STREET ADDRESS, CITY, STATE, ZIP CODE: 500 Waterfront Drive East Providence, RI 02914	

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review revealed Resident ID #13 was readmitted to the facility in November of 2024 with diagnoses including, but not limited to, dementia and hypertension. Review of the February 2025 MAR revealed the following physician's orders were documented as administered and charted late on 2/10/2025 at 1:16 PM, and on 2/11/2025 at 12:22 PM: -Amlodipine (a medication prescribed to treat high blood pressure) 5 milligrams (mg) once every morning, pre-breakfast -Eliquis (a blood thinner) 2.5 mg administer twice a day, post-breakfast -Labetalol (a medication prescribed to treat high blood pressure) 100 mg twice a day, post-breakfast During surveyor interviews on 2/11/2025 at 12:09 PM and on 2/12/2025 at 1:58 PM with Certified Medication Technician, Staff D, she indicated that the time charted on the MAR, is the time that she administered the medication. She further acknowledged that she documented that she charted late on the MAR for the Amlodipine, Eliquis, and Labetalol, however the medications were in fact, administered late. During a surveyor interview on 2/13/2025 at 11:03 AM with the DNS, she indicated that she would expect that a medication that is administered later than the scheduled time, would be documented as administered late, and not as charted late. 46118

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41729 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infection, relative to droplet/contact precautions (utilized when a resident is known or expected to be infected to prevent the spread of germs that can be transmitted through respiratory droplets expelled when a person coughs, sneezes, or speaks) for 1 of 2 residents reviewed on droplet/contact precautions for influenza (a highly contagious respiratory illness caused by the influenza viruses which spreads through respiratory droplets), Resident ID #19. Findings are as follows: Review of the facility's policy titled, Isolation-Categories of Transmission-Based Precautions states in part, Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection .and is at risk of transmitting the infection to other residents .Contact Precautions: are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces .Staff wear gloves when entering the room .Droplet Precautions .Gloves, gown and goggles are worn if there is a risk of spraying respiratory secretions . Record review revealed the resident was admitted to the facility in February of 2024 with a diagnosis including, but not limited to, dementia. Record review of a progress note dated 2/6/2025 revealed the resident tested positive for influenza. Record review of a physician's order dated 2/11/2025 to maintain droplet/contact precautions for influenza, every shift. During a surveyor observation on 2/10/2025 at approximately 9:40 AM revealed the resident had signage posted on his/her door indicating that s/he was on droplet/contact precautions. Additionally, the signage indicated that staff should wear a gown, gloves, and eye protection prior to entering the room. During a surveyor observation on 2/10/2025 at 9:43 AM, revealed Nursing Assistant, Staff F, entering the resident's room with a tray of food and placed it on the table without wearing gloves or eye protection. Staff F exited the room, put on a pair of gloves, then reentered the resident's room and assisted him/her with his/her meal and did not wear eye protection. During a surveyor interview immediately following this observation with Staff F, she acknowledged that she did not wear eye protection and gloves prior to entering the resident's room. Staff F further indicated that she only wears eye protection when she is assisting the resident with his/her personal care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 2/13/2025 at 11:01 AM with the Infection Preventionist, she indicated that the staff is expected to wear gloves and eye protection prior to entering the resident's room. During a surveyor interview on 2/13/2025 at 11:03 AM with the Director of Nursing Services, she indicated that she would expect the staff to wear gloves and eye protection prior to entering the resident's room. 46118