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	04/16/2026

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on clinical record review and staff interview, the facility failed to ensure that hospice services meet professional standards of principles that apply to individuals providing services in the facility for 2 of 2 residents reviewed who are receiving hospice services, Resident ID #s 6 and 8.Findings are as follows:1. Record review revealed that Resident ID #6 was admitted to the facility in March of 2026 with a diagnosis including, but not limited to, dementia.Record review revealed the resident began receiving hospice services on 3/23/2026.a. Record review failed to reveal evidence that a Significant Change Minimum Data Set (MDS) Assessment was completed within 14 days from the date s/he began receiving hospice services, as per the regulation.During a surveyor interview on 4/15/2026 at 10:39 AM with the MDS Coordinator, Staff C, she revealed that Significant Change Assessments are completed when a resident begins receiving hospice services, and the assessment should be completed within 14 days. Additionally, she acknowledged that the Significant Change Assessment had not been completed for the resident.Further record review revealed the Significant Change Assessment was completed on 4/15/2026, after it was brought the facility's attention by the surveyor.b. Review of the electronic and paper medical records failed to reveal evidence of the following hospice information, per the regulation: - The most recent hospice plan of care- Physician certification and recertification of the terminal illness- Names and contact information for hospice personnel involved in hospice care- Hospice medication information- Hospice physician and attending physician orders- Delineation of the hospice's responsibilitiesDuring a surveyor interview on 4/15/2026 at 10:48 AM with the Director of Nursing Services (DNS), she revealed that the facility does not have individual hospice binders for each resident receiving hospice services. She was unable to provide evidence of the above-mentioned hospice documents for Resident ID #6 until after it was brought to the facility's attention by the surveyor.2. Record review revealed Resident ID #8 was admitted to the facility in January of 2026 with a diagnosis including, but not limited to, dementia.Record review revealed the resident began receiving hospice services in February of 2026.Review of the electronic and paper medical records on the morning of 4/15/2026, failed to reveal evidence of the following hospice information, per the regulation:- The most recent hospice plan of care- Hospice election form- Physician certification and recertification of the terminal illness- Names and contact information for hospice personnel involved in hospice care- Instructions on how to access the hospice's 24-hour on-call system- Hospice medication information- Hospice physician and attending physician orders- Delineation of the hospice's responsibilitiesDuring a surveyor interview on 4/15/2026 at 12:57 PM, with the DNS, she acknowledged the hospice documentation was obtained and placed in the resident's chart after it was brought to the facility's attention by the surveyor. Additionally, she was unable to provide evidence that the facility ensured that hospice services meet professional standards of principles for Resident ID #s 6 and 8 related to having the required hospice documentation.

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

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	04/16/2026

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on clinical record review and staff interview, the facility failed to provide appropriate treatment and services related to monitoring output for 2 of 4 residents reviewed with an indwelling catheter (a flexible tube that collects urine from the bladder and leads to a drainage bag), Resident ID #s 9 and 10.Findings are as follows:According to Brunner & Suddarth's Textbook of Medical-Surgical Nursing Volume 2, 10th Edition, page 1282 and 1284 states in part, .For patients with indwelling catheters, the nurse assesses the drainage system to ensure that it provides adequate urinary drainage. The color, odor, and volume of urine are also monitored. An accurate record of fluid intake and urine output provides essential information about the adequacy of renal function and urinary drainage .to reduce the risk of bacterial proliferation [rapid increase in numbers] empty the collection bag at least every 8 hours through the drainage spout - more frequently if there is a large volume of urine .Review of an undated facility policy titled, Emptying a Urinary Collection Bag states in part, .to prevent the collection bag from becoming full and allowing urine to flow back into the bladder and to measure output.empty the urinary collection bag at least every eight (8) hours or more often if needed.the following information should be recorded in the resident's medical record.the amount of urine emptied from the drainage bag.1. Record review revealed Resident ID #9 was admitted to the facility in January of 2025 with a diagnosis including, but not limited to, neuromuscular dysfunction of the bladder (a condition caused by a problem with the brain, nerves, or spinal cord which causes a loss of control of the bladder).Review of the care plan revealed the resident has an indwelling foley catheter and is at risk for developing a urinary tract infection.Record review revealed a physician's order dated 2/19/2025 to monitor foley output every shift.Record review failed to reveal evidence that urine output was documented on the following days and shifts:4/2- 3rd and 1st shift 4/3- 1st and 2nd shift4/4- 2nd shift4/7- 1st shift4/10- 3rd and 1st shift4/11- 1st shift4/13- 1st shiftDuring a surveyor interview on 4/15/2026 at 3:18 PM with Registered Nurse (RN), Staff A, he indicated that urine output should be documented in the electronic medical record.2. Record review revealed Resident ID #10 was admitted to the facility in January of 2024 with a diagnosis including, but not limited to, flaccid neuropathic bladder (a condition caused by nerve damage to the bladder leading to weak bladder muscles and the inability for the bladder to contract effectively to empty urine).Review of the care plan revealed the resident has a suprapubic tube (a flexible catheter inserted directly into the bladder through a small incision in the lower abdomen to drain urine when normal urination is not possible) and is at risk for developing a urinary tract infection with interventions including, but not limited to, monitor and record urinary output. Record review failed to reveal evidence that urine output was documented on the following days and shifts:4/1- 1st and 2nd shift4/2- 1st and 2nd shift4/3- all three shifts4/4- all three shifts4/5- 1st and 2nd shift4/6- 1st and 2nd shift4/7- all three shifts4/8- all three shifts4/9- all three shifts4/10- 1st and 2nd shift4/11- 3rd and 1st shift4/12- 2nd shift4/13- 1st and 2nd shift4/14- 1st and 2nd shiftDuring a surveyor interview on 4/14/2026 at 2:11 PM with RN, Staff B, she revealed urinary output from a urinary catheter should be documented each shift in the resident's electronic medical record. Additionally, she acknowledged that urinary output had not been documented each shift for Resident ID #10.During surveyor interviews on 4/14/2026 at 2:34 PM and on 4/15/2026 at 1:57 PM with the Director of Nursing Services, she revealed that she would expect urinary output from a urinary catheter to be documented each shift. Additionally, she acknowledged that urinary output had not been documented on each shift for Resident ID #s 9 and 10.