

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Stillwater Assisted Living and Skilled Nursing Com		STREET ADDRESS, CITY, STATE, ZIP CODE 20 Austin Avenue Greenville, RI 02828	
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on clinical record review and staff interview, the facility failed to ensure that residents are free from significant medication errors for 1 of 1 resident reviewed receiving the medication Ertapenem (an antibiotic prescribed to treat serious bacterial infections) intravenously (IV), Resident ID #82; and for 1 of 1 resident reviewed receiving the medication Bumetanide (a diuretic prescribed to increase the excretion of urine to help relieve fluid retention), Resident ID #61. Findings are as follows: 1. Record review revealed Resident ID #82 was readmitted to the facility in June of 2026 with a diagnosis of a urinary tract infection with ESBL (extended beta lactamase infection; a multidrug resistant organism that produces enzymes capable of destroying many common antibiotics). Review of a hospital Continuity of Care document dated 6/26/2026, revealed an order for Ertapenem 500 milligrams (mg) IV once daily for 8 days for ESBL. Record review of the physician's orders revealed the Ertapenem order was transcribed incorrectly as, Ertapenem 1 gram (which is equal to 1000 mg) IV one time a day x 8 days. Record review of the June 2026 Medication Administration Record (MAR) indicated that the Ertapenem 1 gram IV was signed off as administered on 6/27, 6/28 and 6/29/2026, indicating the resident received double the amount of the antibiotic that was ordered. During a surveyor interview on 7/3/2026 at 1:56 PM, with Registered Nurse, Staff A, she acknowledged that she transcribed the order for Ertapenem incorrectly as 1 gram daily instead of 500 mg daily. During a surveyor interview on 7/1/2026 at 3:00 PM, with the Director of Nursing Services (DNS), she revealed that a review of the admission orders should have been completed by the nurse that was working with Staff A to ensure the accuracy of the orders that were transcribed. The DNS further acknowledged that the Ertapenem IV order was transcribed incorrectly, which resulted in the resident receiving the incorrect dose of the antibiotic. 2. Record review revealed Resident ID #61 was admitted to the facility in December of 2022 with diagnoses including, but not limited to, heart failure (a condition when the heart muscle does not pump blood as effectively as it should) and chronic kidney disease. Record review of the physician's orders revealed an order dated 6/22/2026, for Bumetanide 2 mg twice daily; every Monday, Wednesday, and Friday for edema (swelling that is caused by excess fluid trapped in the body's tissues), with a stop date of 6/26/2026. Record review of a provider progress note dated 6/26/2026, revealed Resident ID #61 was assessed by his/her physician for fluid volume overload and heart failure symptoms. Further review of the progress note revealed the resident experienced an increase in weight and bilateral (affecting both sides) lower extremity edema. As a result, the physician ordered an increase to the resident's Bumetanide to 2 mg twice daily and to repeat a basic metabolic panel (a blood test) in one week. Record review of a physician's order dated 6/26/2026 for Bumetanide 2 mg twice daily revealed it was incorrectly transcribed with a start date of 7/3/2026. Further record review of the June and July 2026 MARs failed to reveal evidence the order for Bumetanide was initiated on 6/26/2026, indicating that the resident did not receive Bumetanide on 6/27, 6/28, 6/29, 6/30, 7/1, and 7/2, a total of 12 doses. During a surveyor interview on 7/3/2026 at (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
--	-------	-----------

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Stillwater Assisted Living and Skilled Nursing Com		STREET ADDRESS, CITY, STATE, ZIP CODE 20 Austin Avenue Greenville, RI 02828	
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1:02 PM, with the resident's physician, he revealed that he was unaware that Resident ID #61 had not received his/her Bumetanide since 6/26/2026. Additionally, he indicated that he ordered to increase the Bumetanide to 2 mg twice daily on 6/26/2026 and he would have expected the new order to start on 6/27/2026. During a surveyor interview on 7/3/2026 at 2:25 PM, with the DNS, she acknowledged that the resident was not administered his/her Bumetanide since 6/26/2026, as ordered, and missed a total of 12 doses. Cross reference F842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Stillwater Assisted Living and Skilled Nursing Com		STREET ADDRESS, CITY, STATE, ZIP CODE 20 Austin Avenue Greenville, RI 02828	
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 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. Based on clinical record review and staff interview, the facility failed to ensure that medical records for each resident are complete and accurately documented for 2 of 2 resident reviewed who experienced significant medication errors, Resident ID #s 82 and 61. Findings are as follows: 1. Record review revealed Resident ID #82 was readmitted to the facility in June of 2026 with a diagnosis of a urinary tract infection with ESBL (extended beta lactamase infection; a multidrug resistant organism that produces enzymes capable of destroying many common antibiotics). Review of a hospital Continuity of Care document dated 6/26/2026 revealed an order for Ertapenem (an antibiotic prescribed to treat serious bacterial infections) intravenously (IV) 500 milligrams (mg) once daily for 8 days for ESBL. Record review of the June 2026 Medication Administration Record (MAR) revealed that the order was transcribed inaccurately for Ertapenem as 1 gram IV daily instead of the intended 500 mg daily, which resulted in the resident receiving double the intended dose, for three days. During a surveyor interview on 7/3/2026 at 1:56 PM, with Registered Nurse, Staff A, she acknowledged that she inaccurately transcribed the order for Ertapenem as 1 gram daily instead of 500 mg daily, as ordered. During a surveyor interview on 7/1/2026 at 3:00 PM, with the Director of Nursing Services (DNS), she acknowledged that the Ertapenem IV order was inaccurately transcribed. 2. Record review revealed Resident ID #61 was admitted to the facility in December of 2022 with diagnoses including, but not limited to, heart failure (a condition when the heart muscle does not pump blood as effectively as it should) and chronic kidney disease. Record review of the physician's orders revealed an order dated 6/22/2026 for Bumetanide 2 mg twice daily every Monday, Wednesday, and Friday for edema (swelling that is caused by excess fluid trapped in the body's tissues), with a stop date of 6/26/2026. Record review of a provider progress note dated 6/26/2026 revealed Resident ID #61 was assessed by his/her physician for fluid volume overload and heart failure symptoms. As a result, the physician ordered an increase to the resident's Bumetanide to 2 mg twice daily and to repeat a basic metabolic panel (a blood test) in one week. Further record review of the June and July 2026 MARs revealed evidence that the order for Bumetanide was transcribed with an inaccurate start date of 7/3/2026, resulting in the resident not receiving Bumetanide on 6/27, 6/28, 6/29, 6/30, 7/1, and 7/2, a total of 12 missed doses. During a surveyor interview on 7/3/2026 at 1:02 PM, with the resident's physician, he indicated that he ordered to increase the Bumetanide to 2 mg twice daily on 6/26/2026 and that he would have expected the new order to start on 6/27/2026. During a surveyor interview on 7/3/2026 at 2:25 PM, with the DNS, she acknowledged that the order for Bumetanide was transcribed inaccurately to start on 7/3/2026 instead of 6/27/2026, as ordered. Cross reference F760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Stillwater Assisted Living and Skilled Nursing Com		STREET ADDRESS, CITY, STATE, ZIP CODE 20 Austin Avenue Greenville, RI 02828	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on surveyor observation, clinical record review, and staff interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections related to contact precautions (an infection control intervention designed to reduce the transmission of diseases and infections spread by direct and indirect physical contact, requiring staff to wear a gown and gloves before entering a resident's room) for 2 of 3 residents observed on contact precautions, Resident ID #s 87 and 91. Findings are as follows: Review of an undated facility policy titled, Guidelines for Management of MDROs, states, in part: .MDROs (multi-drug resistant organisms) are increasingly important causes of infection and colonization in long-term care facilities .Placement of the resident: Ideally, a resident on Contact Precautions should be placed in a private room. If a private room is unavailable, the resident may be placed in a room with another resident who has the same microorganism and no other known infection or colonization with a different MDRO .1. Record review revealed Resident ID #87 was admitted to the facility in June of 2026 with diagnoses including, but not limited to, vascular dementia and acute respiratory failure. Record review revealed Resident ID #87 was diagnosed with MRSA (an MDRO strain of bacteria that has developed a resistance to many common antibiotics) in the nares and was placed on contact precautions. Record review revealed the following physician's orders:-6/28/2026 for Contact Precautions requiring staff to wear gowns and gloves upon entering the room and to wear a face mask and eye protection if splashes or sprays were anticipated.-6/28/2026 for Mupirocin 2% external ointment (a medication prescribed to treat bacterial skin infections), to be applied to the nares three times daily for five days for MRSA.2. Record review revealed Resident ID #91 was readmitted to the facility in June of 2026 with diagnoses including, but not limited to, vascular dementia and urinary tract infection. Record review of the census report revealed Resident ID #91 was placed in a room with Resident ID #87 upon his/her readmission to the facility. During surveyor observation on 7/1/2026 at approximately 10:00 AM, Resident ID #91 was observed residing in the same room with Resident ID #87. Additional observation revealed signage posted at the doorway indicating the room was under Contact Precautions. Immediately following the above observation, during an interview with Registered Nurse, Staff B, she stated that she was unsure if Resident ID #91 had MRSA upon readmission, but revealed Resident ID #87 had an established MRSA diagnosis. Clinical record review failed to reveal evidence that Resident ID #91 had a diagnosis of MRSA. Record review of a progress note dated 7/1/2026 at 1:42 PM revealed, education was provided to Resident ID #91's spouse regarding the resident's exposure to his/her roommate who had MRSA. A room change was initiated; Resident ID #91 was being moved to another room and was placed on Contact Precautions due to being exposed to his/her roommate with MRSA. During a surveyor interview on 7/1/2026 at 2:46 PM with the Director of Nursing Services, she revealed that she was informed by the admission Coordinator that the hospital paperwork indicated that Resident ID #91 was positive for MRSA and upon returning to the facility from the hospital on 6/30/2026, s/he was placed in a room with Resident ID #87, who was already on Contact Precautions for MRSA. The DNS further revealed that on 7/1/2026, after the surveyor brought this concern to the facility's attention, the hospital records were reviewed, and the documentation failed to reveal that Resident ID #91 was positive for MRSA upon readmission. The DNS acknowledged that Resident ID #91 should not have been placed in a room with Resident ID #87 who was positive for MRSA.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Stillwater Assisted Living and Skilled Nursing Com		STREET ADDRESS, CITY, STATE, ZIP CODE 20 Austin Avenue Greenville, RI 02828	
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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on record review and staff interview, the facility failed to provide mandatory in-service training relative to the Quality Assurance and Performance Improvement (QAPI) program that outlines and informs staff of the elements and goals of the program for 3 of 10 staff reviewed; Staff C, D, and E. Additionally the facility failed to provide required in-service training for nurse aides, to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year, including dementia management training and resident abuse prevention for 1 of 5 nurse aides reviewed, Staff F. Findings are as follows:1. Record review failed to reveal evidence mandatory training for QAPI was completed for the following staff within the last year:-Cook, Staff C-Cook, Staff D-Nursing Assistant, Staff EDuring a surveyor interview on 7/3/2026 at approximately 11:00 AM with the Administrator, he was unable to provide evidence that Staff C, D, and E received training for QAPI, as required.2. Record review failed to reveal evidence that any mandatory in-service training was completed by Staff F within the last year. During a surveyor interview on 7/3/2026 at approximately 11:00 AM with the Administrator, he was unable to provide evidence that Staff F completed mandatory in-service training, as required.		