STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415097	A. BUILDING _____ B. WING _____	07/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANSION NURSING AND REHAB CENTER	104 CLAY STREET CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification Survey, and complaint investigation survey, ACTS Reference Numbers 95219, 96421 and 96253 was conducted at Mansion Nursing and Rehab Center from 7/1/2024 through 7/5/2024 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. A State licensure and emergency preparedness surveys were also conducted at this facility. Deficiencies were cited as a result of this survey.	F 000	The filing of this Plan of Correction (POC) does not constitute that the deficiencies alleged did in fact exist, rather this POC is filed as evidence of the facility's continuing commitment to high quality resident care in full compliance with state and federal regulations. Completion date for optimal compliance with the POC August 4, 2024	
F 567 SS=B	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(10)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting	F 567	**As a Plan of Correction (POC) for Federal Tag F 567** a) Resident ID # 10 and #38 continue to reside in the facility and now have signed authorizations for the facility to hold their personal funds. b) Residents who authorize the facility to hold their funds have the potential to be affected by this finding. The files of residents that the facility holds funds for have been reviewed to ensure that the authorization has been signed. We have made needed corrections.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Teresa Chapman — TITLE: ADMINISTRATOR — (X6) DATE: 7/25/24

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.

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F 567	Continued From page 1 for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to obtain written authorization for residents whom the facility is holding personal funds relative to 2 of 6 residents reviewed Resident ID #s 10 and 38. Findings are as follows: Record review of the facility's records related to personal needs funds revealed a document titled, "List of Residents Managed by Administrator" revealed the facility was holding funds for Resident ID #s 10 and 38. 1. Record review revealed that Resident ID #10 was admitted to the facility in September of 2011. Record review of a "Personal Needs account " balance document revealed Resident ID #10 had a current balance of $4,379.42 on 6/10/2024. Record review of an "Exhibit 'A' Authorization	F 567	c) The authorization form is included in the admission packet to determine how the resident/ family wants the facility to manage personal funds. At the time the authorization is received, the form is to be completed and signed. To ensure compliance, we have created a checklist of documents to be signed at the time of admission which includes the authorization form. The checklist will be reviewed within 10 days of admission so that needed corrections can be made timely. We have devised an audit to monitor our progress with this plan. d) The Administrator or designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 3 months; at which time, we will determine the need/frequency to continue formal audits.	

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F 567	Continued From page 2 Document " form dated 9/9/2011 revealed that the resident did not authorize the facility to hold their funds. 2. Record review revealed that Resident ID #38 was admitted to the facility in November of 2023. Record review of a "Personal Needs account" balance document revealed Resident ID #38 had a current balance of $125.00 on 5/14/2024. Record review of an "Exhibit 'A' Authorization Document" form dated 11/7/2023 revealed that the resident did not authorize the facility to hold their funds. During a surveyor interview on 7/5/2024 at 11:27 AM with the Administrator, she acknowledged that the facility did not have written authorization to hold the funds for Resident ID #s 10 and 38.	F 567		
F 568 SS=B	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by:	F 568	**As a Plan of Correction (POC) for Federal Tag F 568** a) Residents ID # 3 and 38 continue to reside in the facility. They have received a written accounting of their deposits, withdrawals and balances for the current quarter.	

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F 568	Continued From page 3 Based on record review and staff interview, it has been determined that the facility failed to ensure that each resident was given a written accounting of his/her deposits, withdrawals, and balances at least quarterly for 2 of 6 residents reviewed, Resident ID #s 3 and 38. Findings are as follows: 1. Record review revealed that Resident ID #3 was admitted to the facility in May of 2023. Review of a facility provided document titled, "Personal Needs Account" revealed that Resident ID #3 has funds being held by the facility. Record review failed to reveal evidence that any quarterly statements were completed and given to Resident ID #3. 2. Record review revealed that Resident ID #38 was admitted to the facility in November of 2023. Review of a facility provided document titled, "Personal Needs Account" revealed that Resident ID #38 has funds being held by the facility. Record review failed to reveal evidence that any quarterly statements were completed and given to Resident ID #38. During a surveyor interview on 7/5/2024 at 11:27 AM with the Administrator, she acknowledged that Resident ID #s 3 and 38 had not been provided a written accounting of his/her deposits, withdrawals, and balances at least quarterly per the regulation.	F 568	b) Residents who authorize the facility to hold their funds have the potential to be affected by this finding. We have reviewed each to ensure they have received a current accounting of deposits, withdrawals and balances. We have made corrections as necessary. c) We have reviewed this regulation and understand the importance of informing residents that we hold funds for, with an accounting of their personal financial status on a quarterly basis. We will maintain a master list of all those we hold funds for and compare it to the quarterly reports that are distributed to ensure each resident received the accounting report. We have an audit tool to monitor our progress with this plan. d) The Administrator or designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 3 months; at which time, we will determine the need /frequency to continue formal audits.	
F 569 SS=B	Notice and Conveyance of Personal Funds	F 569		

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F 569	Continued From page 4 CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it has been determined that the facility failed to notify each resident, or resident representative, that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the Social Security Income (SSI) resource limit for 3 of 6 residents reviewed for personal needs funds handled by the facility, Resident ID #s 10, 16 and 17. Findings are as follows: Title 210-Executive Office of Health and Human	F 569	**As a Plan of Correction (POC) for Federal Tag F 569** a) Residents ID # 10, 16 and 17 have been given notification that their accounts are over the SSI income limit. b) Residents who authorize the facility to hold their funds have the potential to be affected by this finding. We have reviewed the accounts of each of them to ensure that they are within the limits and if not have made the needed notifications. c) We have reviewed this regulation and understand the importance of monitoring the accounts and notifying those affected that they are reaching the allowable limit. Going forward we will maintain a list of the current account balances, which will be reviewed no less than quarterly to anticipate any	

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F 569	Continued From page 5 Services, Chapter 50-Medicaid Long-Term Services and Supports (LTSS) under section 2.4 (G) of the "Uniform Accountability Procedures for Title XIX Resident Personal Needs Funds in Community Nursing Facilities, ICF/DD Facilities, and Assisted Living Residences" requires that the facility shall: "...(10) The nursing facility must notify the resident in writing when his/her balance reaches $200.00 less than the resource eligibility guideline, that Medicaid eligibility is jeopardized if the account exceeds the guideline[4,000]..." Review of facility documents titled, "List of Resident Managed by Administrator" and "Personal Needs Account" for the following residents states in part: - Resident ID #10 has a current balance of $4,370.42. - Resident ID #16 has a current balance of $4,549.22. - Resident ID #17 has a current balance of $4,186.66. During a surveyor interview on 7/5/2024 at 11:27 AM with the Administrator, she was unable to provide evidence that the above identified residents were notified in writing that their account balances reached $200 less than the SSI Medicaid eligibility resource limit (4,000).	F 569	approaching limits so that notifications are made timely. We have devised an audit to monitor for compliance with this plan. d)The Administrator or designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI Committee monthly for no less than 3 months; at which time, we will determine the need/frequency to continue formal audits.	
F 583 SS=B	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.	F 583		

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F 583	Continued From page 6 §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide residents with the right to personal privacy and confidentiality of his/her personal and medical records relative to the posting of past survey results. Findings are as follows:	F 583	**of Correction (POC) for g F583** a) The names on prior posted survey rosters were removed as soon as we were made aware during the survey. b) Residents who are listed on a survey roster have the potential to be affected by this finding. All previous names on rosters have been removed from the posting area. c) We have re-educated staff about the importance of maintaining confidentiality of personal information and the privacy of records in relation to posting of resident names. We have raised their level of awareness of the need to protect medical information. We have an audit tool to monitor for compliance. d) The Administrator or designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI Committee monthly for no less than 3 months at which time we will determine the need/frequency to continue formal audits.	

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F 583	Continued From page 7 During a surveyor observation of the main hallway area on 7/3/2024 at 8:15 AM, revealed a "Survey Results" envelope. In the envelope there were copies of previous survey rosters which included identifying information of residents from the following survey dates: Record review of the " Survey Results" envelope revealed the following: - "Resident/Staff Roster" form dated 10/4/2019 with four residents identified, ID #s 11, 106, 107 and 108. - "Resident/Staff Roster" form dated 4/15/2021 with nine residents identified, ID #s 16, 109, 110, 111, 112, 113, 114, 115 and 116. - "Resident/Staff Roster" form dated 6/16/2022 with eleven residents identified, ID #s 14, 17, 22, 42, 115, 117, 118, 119, 120, 121 and 122. - "Resident/Staff Roster" form dated 7/21/2023 with three residents identified, ID #s 44, 123, and 124. During a surveyor interview on 7/3/2024 at 8:30 AM with the Director of Nursing Services, she acknowledged that the resident rosters on the above-mentioned dates were available with the "Survey Results".	F 583		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658		

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F 658	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that services being provided meet professional standards of practice relative to following a physician's order for 1 of 1 residents reviewed for significant weight gain, Resident ID #38. 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 the orders are in error or would harm the clients." Record review revealed the resident was admitted to the facility in November of 2023 with a diagnosis including, but not limited to, type II diabetes mellitus. Review of a Minimum Data Set Assessment dated 6/7/2024 revealed a Brief Interview for Mental Status score of 15 out of 15, indicating intact cognition. Review of a progress note authored by the Registered Dietician, Staff A, dated 6/9/2024 revealed s/he continues with significant weight gain and recommends bloodwork to check his/her thyroid panel. Record review of a physician's order dated 6/19/2024 for bloodwork to include the following: T-3 total, T-3 Uptake (blood tests that help diagnose thyroid conditions, specifically	F 658	**As a Plan of Correction (POC) for Federal Tag F 658** a) Resident ID # 38 has had the lab test as ordered by the physician. b) Residents who have physician orders for laboratory testing have the potential to be affected by this finding. We have reviewed our process to ensure that the lab tests were performed in a timely manner and that refusals are documented and reported to the physician and followed up as ordered.. We have made needed corrections. c) We have provided re-education for the nurses on the importance of ensuring laboratory tests are done as ordered by the physician. We have reviewed our system for ordering labs and following up to ensure that refused labs are documented and reported to the physician in a timely manner. We have an audit tool to monitor for compliance.	

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F 658	Continued From page 9 hyperthyroidism) and TSH (blood test to find out if your thyroid gland is working properly). Record review failed to reveal evidence of the above lab work results or documentation that it was completed. During a surveyor interview on 7/3/2024 at 9:59 AM with Registered Nurse, Staff B, she acknowledged that the physician's order was not followed, and the lab work was not completed per the physician's order on 6/19/2024. During a surveyor interview on 7/3/2024 at 1:30 PM with the Director of Nursing Services, she revealed that she would expect the lab work to be completed per the physician order.	F 658	d) The DNS/designee is responsible for implementing this plan. Routine audits will be conducted for compliance with the plan. Results will be reported to the QAPI Committee monthly for no less than 3 months to determine the need/frequency to continue formal audits. 7/26/24	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide respiratory care consistent with professional standards of practice for 1 of 2 residents reviewed for respiratory care, Resident ID #47.	F 695	**As a Plan of Correction (POC) for Federal Tag F 695** a) Residents ID # 47 is receiving oxygen at the correct flow rate. b) Residents who receive oxygen have the potential to be affected by this finding. We reviewed the residents who receive oxygen to ensure their orders are being followed.	

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F 695	Continued From page 10 Findings are as follows: Record review of a facility policy titled, "ProCare Oxygen Administration" states in part, "...A physician's order is necessary for the administration of oxygen...Verified the physician's order and review the patient chart...verify flow of oxygen..." Record review revealed Resident ID #47 was readmitted to the facility in June of 2024 with a diagnosis including, but not limited to, Chronic Obstructive Pulmonary Disease (a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe). Review of a physician's order dated 6/21/2024 revealed an order for the resident to receive oxygen at 2 liters via a nasal cannula (a tubing that delivers oxygen into your nose) every shift. During surveyor observations on the following dates and times, the resident was observed receiving oxygen at the following flow rate: -7/1/2024 at 11:50 AM, the resident was receiving 3 liters of oxygen -7/2/2024 at 8:32 AM, the resident was receiving 2.5 liters and at 1:40 PM the resident was receiving 3 liters of oxygen -7/3/2024 at 8:28 AM, 11:48 AM, and at 1: 13 PM, the resident was receiving 3 liters of oxygen During a surveyor observation on 7/3/2024 at 1:26 PM in the presence of the Director of Nursing Services (DNS) and a Registered Nurse, Staff B, they revealed the resident was receiving 3 liters of oxygen instead of the 2 liters as	F 695	c) We have provided education to nurses regarding the importance of following physician orders for oxygen use. We have reviewed our method of monitoring oxygen use to include documentation of the amount being administered on every shift. We have an audit in place to monitor our compliance with this plan. d) The DNS/designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared monthly with the QAPI Committee for no less than 3 months at which time, we will determine the need/frequency to continue formal audits.	

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MANSION NURSING AND REHAB CENTER	104 CLAY STREET CENTRAL FALLS, RI 02863

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F 695	Continued From page 11 ordered. During a surveyor interview immediately following this observation the DNS and Staff B acknowledged the resident was receiving 3 liters of oxygen instead of 2 liters as ordered.	F 695		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that	F 761	**As a Plan of Correction (POC) for Federal Tag F 761** a) There were no residents identified in this citation. b) Residents who receive medications have the potential to be affected by this finding. We have ensured that medications are being stored as required. c) We have provided education to the nurses regarding the importance of proper medication storage to	

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F 761	Continued From page 12 the facility failed to store all drugs and biological's in accordance with currently accepted professional principles for 1 of 1 medication storage room observed, 1 of 1 medication refrigerator, and 2 of 3 medication carts observed (Mansion One and Two). Findings are as follows: Review of the facility policy titled "LTC Facility's Pharmacy Services and Procedures Manual" with a revision date of 8/7/2023 states in part, "Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record date opened on the primary medication container when the medication has a shorter expiration date once opened...If a multi-dose vial of an injectable medication has been opened or accessed, the vial should be dated and discarded within 28 days unless the manufacturer specifies a different date for the opened vial..." 1. Surveyor observation of the medication refrigerator on the first floor on 7/2/2024 at 11:28 AM in the presence of License Practical Nurse (LPN), Staff C, revealed a bottle of tuberculin purified protein derivative solution (a solution used in a skin test to help diagnose tuberculosis) opened and not dated. During a surveyor interview immediately following this observation with Staff C, she acknowledged the above-mentioned solution was opened and not dated. 2. Surveyor observation of the Mansion One medication cart narcotic drawer on 7/2/2024 at	F 761	include manufactures' expiration dates and shortened expiration dates when required. Inspections of all medication storage areas are being done on a routine basis to identify any outdated medications (by manufactures or shortened expiration dates) so that corrections are made on an ongoing basis. We have an audit in place to monitor for compliance with this plan. d) The DNS/designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee monthly for no less than 3 months at which time, we will determine the need/frequency to continue formal audits.	

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F 761	Continued From page 13 11:35 AM, in the presence of a LPN, Staff D revealed a packet of 31 tablets of Lorazepam 0.5 milligrams (mg- a medication used to treat anxiety) with a discontinue date of 3/13/2024. During a surveyor interview immediately following this observation with Staff D, she acknowledged the medication should have been removed from the drawer. 3. Surveyor observation of the Mansion Two medication cart on 7/2/2024 at 11:44 AM in the presence of Staff D revealed a Trelegy Ellipta 100 microgram (mcg)/62.5 MCG/25 MCG inhaler and a Incruse Ellipta 62.5 MCG inhaler (medications used to treat respiratory disease) opened and not dated. Manufacturer instructions indicate to discard 6 weeks after opening or when the counter reads "0" or whichever comes first. During a surveyor interview immediately following this observation with Staff D, she acknowledged the inhalers were opened and not dated. 4. Surveyor observation of the medication storage room on 7/2/2024 at 12:28 PM in the presence of the Director of Nursing Services (DNS), revealed the following: - Two bottles of Vitamin E 400 international unit with an expiration date of "9/2019" - One bottle of Mucus relief tablet 400 MG with an expiration date of "12/2020" - Two bottles of Fish oil capsules with an expiration date of "9/2019" During a surveyor interview immediately following this observation with the DNS, she acknowledged the above-mentioned medications were expired	F 761		

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F 761	Continued From page 14 and should have been discarded. During an additional interview on 7/3/2024 at 2:05 PM with the DNS, she could not provide evidence the above-mentioned medications were stored appropriately as required.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on surveyor observation 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 1 of 1 ice machine and 1 of 1 kitchenette observed. Findings are as follows:	F 812	**As a Plan of Correction (POC) for Federal Tag F 812** a) There were no residents identified in this citation. b) Residents have the potential to be affected by this finding. The ice machine was cleaned and serviced immediately following this finding. We have taken corrective actions regarding inaccurately labeled opened drinks. c) We have provided education to the dietary staff related to monitoring the ice machine for any residue that may collect on the bottom edge of the dispenser shield. We have developed an audit tool to monitor compliance. We have educated nursing staff to place the correct date of opening on drinks with expiration dates. We have developed an audit tool to monitor compliance.	

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F 812	Continued From page 15 1. During a surveyor observation on 7/1/2024 at 8:40 AM of the ice machine, revealed an accumulation of a pink substance located on the bottommost edge of the ice dispenser shield. Additionally, the pink substance was easily removed by wiping it with a paper towel. During a surveyor interview immediately following the above observation with Licensed Practical Nurse, Staff D, she acknowledged the presence of the above-mentioned pink substance within the ice machine. 2. 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..." Review of the High-calorie (Hi-Cal) oral supplement "Product Information" guide states in part, "...Storage and Handling...Once opened, reclose, label with time and date, refrigerate, cover and use within 48 hours..." During a surveyor observation on 7/1/2024 at approximately 8:40 AM of the kitchenette, revealed 1 opened bottle of Hi-Cal dated 5/7/2024, approximately 3/4th's full. During a surveyor interview immediately following the above observation with Staff D, she acknowledged that the Hi-cal supplement was	F 812	d)The Food Service Manager is responsible for implementing this plan, The audits will be conducted on a routine basis and the results shared with the QAPI Committee monthly for no less than 3 months to determine the need/frequency to continue formal audits. EM 7/24/24	

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F 812	Continued From page 16 dated 5/7/2024 and should have been discarded. During a surveyor interview on 7/1/2024 at 9:00 AM with the Food Service Director, he acknowledged the accumulation of the pink substance within the ice machine and the Hi-Cal supplement dated 5/7/2024. He further revealed the Hi-Cal supplement should be discarded and the ice machine needs to be cleaned.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:		**As a Plan of Correction (POC) for Federal Tag F 880** F 880 a) Residents ID # 20 and 26 remain in the facility and are receiving care according to established infection control principles per the use of Enhanced Barrier Precautions (EBP). There were no residents identified in this citation related to water collection in the scoop. b) Residents who require EBP have the potential to be affected by this finding. We have ensured that EBP is being provided as required. Residents in the facility have the potential to be affected by the water collection on the ice scoop. There were no residents identified in this citation related to the ice scoop. We have made needed corrections. c) We have provided education to nursing staff and other facility staff on the importance of utilizing EBP. We have explained which resident	

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F 880	Continued From page 17 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880	care activities require the use of Personal Protective Equipment (PPE) for residents on EBP. We have made provisions for the same education for temporary staff members who may be assigned to our facility. The Infection Preventionist (IP) has been monitoring staff in their use of EBP. We have made the needed corrections to the ice scoop holder to ensure that the water drains out to prevent water collection. We have created an audit to monitor our compliance with this plan. d) The IP is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 3 months at which time we will determine the need/frequency to continue formal audits.	

EM 7/26/24

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F 880	Continued From page 18 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 designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections related to the implementation of water system management control measures to mitigate the development of Legionella (a very serious type of lung infection caused by the bacteria called Legionella which can be found in water) and other opportunistic waterborne pathogens for 1 of 1 ice scoop and designated container. Additionally, the facility failed to maintain Enhanced Barrier Precautions (EBP; an infection control intervention designed to reduce transmission of multidrug-resistant organisms in nursing homes) for 2 of 3 residents reviewed, Resident ID #s 20 and 26. Findings as follows: 1) Record review of the Centers for Disease Control and Prevention document titled, "Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings", dated June 2021, 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..." During a surveyor observation of the nourishment area on 7/1/2024 at 8:57 AM, the ice scoop was observed submerged in approximately 2 inches of stagnant water in the designated ice scoop container.	F 880		

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F 880	Continued From page 19 During a surveyor interview immediately following the above observation on 7/1/2024 at 8:59 AM with Licensed Practical Nurse, Staff D, she acknowledged the ice scoop was submerged in approximately 2 inches of stagnant water. During a surveyor interview with the Food Service Director, on 7/1/2024 at 9:05 AM, he acknowledged the above-mentioned observations and stated, "It should not be in standing water", he then removed the ice scoop container from the wall to empty the stagnant water from the container. Additionally, he indicated this was the only ice machine and scoop for the entire facility. 2) Review of the Center for Disease Control and Prevention document titled "Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDROs)" Last Reviewed: August 1, 2023, states in part, "Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing...MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities...The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents...with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: -Dressing -Bathing/showering	F 880		

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F 880	Continued From page 20 -Transferring -Providing hygiene -Changing linens -Changing briefs or assisting with toileting -Device care or use of a device (i.e central lines, urinary catheters, feeding tubes..." 2a) Record review revealed Resident ID #20 was readmitted to the facility in May of 2024 with diagnoses including, but not limited to, dementia and a wound on the right great toe. Surveyor observation of signage posted on the resident's door on 7/2/2024 at approximately 1:40 PM revealed in part, "Enhanced Barrier Precautions; Attention: Caregivers, staff and visitors...Wear Gown and Gloves prior to these activities...During high-contact resident care activities...transferring, changing linen..." During a surveyor observation on 7/2/2024 at approximately 1:44 PM, a Nursing Assistant (NA) Staff E, was observed not wearing a gown as required while in the resident's room changing his/her linens. During a surveyor interview immediately following the above observation with Staff E, she acknowledged that she was changing the resident's linens and failed to wear a gown. 2b) Record review revealed Resident ID #26 was admitted to the facility in May of 2014 with diagnosis including, but not limited to schizoaffective disorder (a mental health condition that is marked by a mixed of symptoms). Surveyor observation of signage posted on the	F 880		

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F 880	Continued From page 21 resident's door on 7/2/2024 at approximately 1:50 PM revealed in part, "Enhanced Barrier Precautions; Attention: Caregivers, staff and visitors...Wear Gown and Gloves prior to these activities...During high-contact resident care activities...transferring...providing hygiene...changing linen..." During a surveyor observation on 7/2/2024 at approximately 1:51 PM, Staff E, she was observed not wearing a gown as required while in the resident's room providing assistance with personal hygiene and toileting. During a surveyor interview immediately following the above observation with Staff E, she acknowledged that she had entered the resident's room and had assisted the resident with personal hygiene and toileting and failed to wear a gown. During a surveyor interview on 7/3/2024 at 2:40 PM with the Director of Nursing Services (DNS) in the presence of the Administrator, she acknowledged that Resident ID #s 20 and 26 are on EBP. She further indicated that she would expect the staff to wear gowns when assisting the residents with toileting, changing linens, and personal hygiene as indicated on the signage posted.	F 880		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 921		

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F 921	Continued From page 22 Based on surveyor observation and staff interview, it has been determined that the facility failed to maintain a safe, functional, and comfortable environment for residents, staff, and the public relative to resident rooms and furnishings in disrepair on 3 of 6 units observed. Findings are as follows: 1) During a surveyor observation on 7/3/2024 at 8:38 AM of the 2nd floor common area revealed an entertainment center with scattered chip marks and pieces of wood that were lifting, resulting in an uneven surface. During a surveyor interview immediately following the above observation with the Operations Manager, he acknowledged that the entertainment center was in disrepair. 2) During a surveyor observation on 7/3/2024 at 1:19 PM of Room 2 on the Mansion 1 Unit, revealed 3 holes in the drywall measuring approximately 7 x 6 inches, 7 x 5 inches, and 19 x 5 inches. Additionally, the paint on the wall over the resident's bed was observed to be chipped. 3) During a surveyor observation on 7/3/2024 at 1:23 PM of Room 5 on the Annex 1 Unit, revealed that the call light system box that was affixed to the wall had exposed wiring coming from the channel. Additionally, the paint was chipped on the wall behind the resident's bed and recliner. During a surveyor interview on 7/3/2024 at approximately 1:25 PM with the Director of Nursing Services, she acknowledged the above findings and indicated they needed to be repaired.	F 921	**As a Plan of Correction (POC) for Federal Tag F 921** a) There were no residents identified in this citation. b) Residents in the facility have the potential to be affected by this finding. We have made corrections to the areas identified in this citation. c) We have provided education to the staff on the need and methods to report any environmental repair required to ensure a safe, functional and comfortable environment. We have re-educated maintenance staff on the already established routine of environmental rounds for the purpose of identifying areas in need of repair.. We have an audit to monitor for compliance with this plan. d) The Operations Manager or designee is responsible for implementing this plan. The audits will be conducted on a routine basis and the results shared with the QAPI Committee monthly. We will review our progress with the QAPI Committee for no less than 3 months; at which time, we will determine the need/frequency to continue formal audits.	

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	LTC00298	A. BUILDING: _____ B. WING _____	07/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANSION NURSING AND REHAB CENTER	104 CLAY STREET CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 715	RESIDENT CARE SERVICES 1.16.6.C Nursing Service & Minimum Staffing 1.16.6.C. Each facility shall have a registered nurse on the premises twenty-four (24) hours a day. In addition, the necessary nursing service personnel (licensed and nonlicensed) shall be in sufficient numbers on a twenty-four (24) hour basis, to assess the needs of resident, to develop and implement resident care plans, to provide direct resident care services, and to perform other related activities to maintain the health, safety and welfare of residents. 1. There shall be a master plan of the staffing pattern for providing twentyfour (24) hour direct care nursing service; for the distribution of direct care nursing personnel for each floor and/or residential area; for the replacement of direct care nursing personnel; and for forecasting future needs. The staffing pattern shall include provisions for registered nurses, licensed practical nurses, nursing assistants, medication technicians, licensed physical therapists, licensed occupational therapists, licensed speech-language pathologists, physical therapist assistants and other personnel as required. 2. Each nursing facility shall include direct caregivers, including at least one (1) nursing assistant, in the process to create the master plan of the staffing pattern and the federally mandated facility assessment. If the nursing assistants in the nursing facility are represented under a collective bargaining agreement, the bargaining unit shall coordinate voting to allow the nursing assistants to select their representative. 3. The number and type of nursing personnel shall be based on resident care needs and classifications as determined for each residential	M 715	**As a Plan of Correction (POC) for Tag M 715** a) There were no residents identified in this citation. b) Residents have the potential to be affected by this finding. We remain aggressive in our efforts to hire registered nurses. c) The facility leadership understands the importance of this regulation and the need for registered nurses to be on the premises 24 hours per day. Providing adequate staffing is a daily, on-going activity at our facility as ensuring safety and professional care is our primary concern. We are and have been actively recruiting RNs through advertisements and word of mouth. We have established and included an increased financial incentive in our	

CM 7/26/24

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M 715	Continued From page 1 area. Each nursing facility shall be responsible to have sufficient qualified staff to meet the needs of the residents. 4. At least two (2) individuals who are certified in Basic Life Support must be available twenty-four (24) hours a day within the nursing facility. One (1) of these individuals must be a licensed nurse. 5. Commencing on January 1, 2022, nursing facilities shall provide a quarterly minimum average specified in R.I. Gen. Laws § 23-17.5-32(c)(i). 6. Commencing on January 1, 2023, nursing facilities shall provide a quarterly minimum average specified in R.I. Gen. Laws § 23-17.5-32(c)(ii). a. In accordance with R.I. Gen. Laws § 23-17.5-32(d), Director of Nursing hours and nursing staff hours spent on administrative duties or non-direct caregiving tasks are excluded and may not be counted toward compliance with the minimum staffing hours requirement in §§ 1.16.6(C)(5) and (6) of this Part. b. Nursing facilities that are certified by the Federal Centers for Medicare and Medicaid Services (CMS) shall access and report data using CMS' payroll-based journal database in accordance with R.I. Gen. Laws § 23-17.5-33(a)(2). c. Nursing facilities that are not certified by CMS (State licensure only) shall report data to the licensing agency in a form and manner as prescribed by the Director.	M 715	advertisements to attract candidates. We have initiated a referral bonus to our present employees to identify RNs for possible employment. d) The Administrator is responsible for implementing this plan. The process of recruitment, hiring and retention of registered nurses will be reported to the QAPI committee quarterly to support our recruitment effort and until such time as we are able to hire qualified registered nurses to ensure 24-hour coverage. We will review our progress with the QAPI Committee on an ongoing basis.	

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M 715	Continued From page 2 7. In accordance with R.I. Gen. Laws § 23-17.5-32(e), the requirements of §§ 16.6.(C)(5) and (6) of this Part are minimum standards only. Nursing facilities shall employ and schedule additional staff as needed to ensure quality resident care based on the needs of individual residents and to ensure compliance with all relevant State and Federal staffing requirements. 8. Compliance and enforcement for § 1.16.6 of this Part shall be done in accordance with R.I. Gen. Laws § 23-17.5-33. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined that the facility failed to ensure that a Registered Nurse (RN) was on the premises twenty-four (24) hours a day for 28 of 38 dates reviewed. Findings are as follows: Record review of schedules provided by the facility dated 5/26/2024 through 7/2/2024 failed to reveal evidence of twenty- four hour RN facility coverage on the following dates: -5/26/2024 -5/27/2024 -5/28/2024 -5/29/2024 -5/31/2024 -6/1/2024 -6/2/2024 -6/4/2024 -6/5/2024 -6/7/2024 -6/8/2024	M 715		

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M 715	Continued From page 3 -6/10/2024 -6/11/2024 -6/12/2024 -6/14/2024 -6/15/2024 -6/16/2024 -6/18/2024 -6/19/2024 -6/21/2024 -6/22/2024 -6/23/2024 -6/24/2024 -6/25/2024 -6/26/2024 -6/28/2024 -6/30/2024 -7/2/2024 During a surveyor interview with the Administrator on 7/3/2024 at approximately 12:30 PM she acknowledged that the facility failed to provide twenty-four hour RN coverage on the above mentioned dates.	M 715		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2024
FORM APPROVED
OMB NO. 0938-0391

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	415097	A. BUILDING _____ B. WING _____	07/05/2024

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by the Center for Health Facilities and Regulation on 7/1/2024. The facility was found to be in compliance with 42 CFR §483.73 related to Emergency Preparedness. Capacity: 62 Census: 55	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Teresa Chapman
TITLE: ADMINISTRATOR
(X6) DATE: 7/25/24

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.

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K 000	INITIAL COMMENTS The annual Federal Life Safety Code survey was conducted by the State Survey Agency on 7/2/2024. Mansion Nursing and Rehabilitation Center was surveyed pursuant to the National Fire Protection Association 101 Life Safety Code, 2012 Edition as referenced in 42 CFR 483.90 (a - d) Physical Environment. Life Safety Code deficiencies were identified during the survey. The facility is NOT in compliance with all regulations surveyed. Capacity: 62 Census: 55	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered	K 161		

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

Teresa Chaponian | ADMINISTRATOR | 7/25/24

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.

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K 161	Continued From page 1 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on a tour of the nursing facility with the Business Operations Associate and after completion of the Fire Safety Evaluation System (FSES) from National Fire Protection Association (NFPA) 101A 2013 edition, it was determined that the facility did achieve a passing score on the second floor in the Mansion Building and the second floor of the Steer/Annex building. Findings are as follows: This facility consists of two buildings that are connected together by a connecting corridor where a resident activities room exists. The main building, Mansion, is 4 stories in height with a full	K 161	Past noncompliance: no plan of correction required.	

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K 161	Continued From page 2 basement where sleeping rooms exist on the 1st and 2nd floors. There are no health care occupancies above the 2nd floor, nor is any space above the 2nd floor accessible to residents. Building is classified as Type V (000). The Steer/Annex building is three stories in height with a full basement where resident sleeping rooms exist on the 1st and 2nd floors. There are no health care occupancies above the 2nd floor. Upon completion of the FSES on 7/3/2024, the facility did achieve a passing score which deems this citation as compliant. Past Non-compliance date of 6/24/2017.	K 161		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the	K 222		

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K 222	Continued From page 3 safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4	K 222	**As a Plan of Correction (POC) for Tag K 222** a) There were no residents named in this citation b) Residents who reside in the facility have the potential to be affected by these findings. c) Immediately following the guidance provided from the surveyor, all doors with alternate locking codes were changed to match those codes known by all staff. Administrative staff with the authorization and access to maintain codes have been educated on the requirement for all door codes to be known and available to all staff. The procedure used to maintain door codes has been edited to include all doors, and for all door codes to be consistent throughout the facility. Regular audits will be completed by the Operations Manager or designee to ensure compliance is maintained. d) The Operations Manager is responsible for this plan of correction. The plan of correction will be reviewed by the QAPI committee for at least three months to ensure compliance is achieved. The plan will be revised as needed.	

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K 222	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to maintain the means of egress with compliant door-locking arrangements in accordance with National Fire Protection Association (NFPA) 101, 2012 edition sections 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6. This deficient practice has the potential to impact 55 residents, as well as an indeterminable number of staff and visitors. Findings are as follows: NFPA 101, 2012 edition section 19.2.2.2.6, states in part, " ...Doors that are located in the means of egress and are permitted to be locked under other provisions of 19.2.2.2.5 shall comply with all of the following: (1) Provisions shall be made for the rapid removal of occupants by means of one of the following: (a) Remote control of locks (b) Keying of all locks to keys carried by staff at all times (c) Other such reliable means available to the staff at all times (2) Only one locking device shall be permitted on each door. (3) More than one lock shall be permitted on each door, subject to approval of the authority having jurisdiction." Surveyor observations on 7/1/2023 revealed that this facility uses numeric keypads as a means to manually release the magnetic locking mechanisms on the exit doors, without activation	K 222		

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K 222	Continued From page 5 of the fire alarm system. Surveyor observations further revealed that the marked exit doors in the following areas had different access codes to manually release the magnetic locking mechanisms: 1. The marked exit door in the first floor main dining room. 2. The marked exit door from the second floor Steer unit, where resident rooms are located. 3. The marked exit door from the second floor Annex unit, where resident rooms are located. During a surveyor interview with a housekeeper, Staff A, on 7/1/2024 at approximately 9:06 AM, she attempted to open the marked exit door in the first floor main dining room, via the keypad, but was unable to do so. She indicated that she was unsure as to why the code she entered was not working. During a surveyor interview with Nursing Assistant, Staff B, on 7/1/2024 at approximately 9:15 AM, she attempted to open the marked exit door in the second floor Steer unit, via the keypad, but was unable to do so. She indicated that she was unsure as to why the code she entered was not working. Surveyor interview with activity staff, Staff C, on 7/1/2024 at approximately 9:22 AM, she attempted to open the marked exit door from the second floor Annex unit, via the keypad, but was unable to do so. She indicated that she was unsure as to why the code she entered was not working. Surveyor interview with Staff D on 7/2/2024 at	K 222		

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K 222	Continued From page 6 approximately 9:10 AM, she attempted to open the marked exit door in the second floor Steer unit, via the keypad, but was unable to do so. She indicated that she was unsure as to why the code she entered was not working. During a surveyor interview with the Business Operations Associate on 7/2/2024 at approximately 9:20 AM, he indicated that the staff were not informed of the access codes because he wants them used for emergencies only. Additionally, he acknowledged that all of the staff should know the access codes to all exit doors that have an electromagnetic locking system with a numeric keypad.	K 222		
K 232 SS=F	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on a tour of the nursing facility with the Business Operations Associate and after completion of the Fire Safety Evaluation System (FSES) from National Fire Protection Association (NFPA) 101A 2013 edition, it was determined that the facility did achieve a passing score for the exit access hallways in the Mansion and the Steer/Annex buildings.	K 232	Past noncompliance: no plan of correction required.	

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K 232	Continued From page 7 Findings are as follows: This facility consists of two buildings that are connected together by a connecting corridor where a resident activities room exists. The main building, Mansion, is 4 stories in height with a full basement where sleeping rooms exist on the 1st and 2nd floors. There are no health care occupancies above the 2nd floor, nor is any space above the 2nd floor accessible to residents. Building is classified as Type V (000). The Steer/Annex building is three stories in height with a full basement where resident sleeping rooms exist on the 1st and 2nd floors. There are no health care occupancies above the 2nd floor. Building is classified as Type V (000). Upon completion of the FSES on 7/3/2024, the facility did achieve a passing score which deems this citation as compliant. Past Non-compliance date of 6/24/2017.	K 232		
K 252 SS=F	Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 This REQUIREMENT is not met as evidenced	K 252		

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	415097	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANSION NURSING AND REHAB CENTER	104 CLAY STREET CENTRAL FALLS, RI 02863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 252	Continued From page 8 by: Based on a tour of the nursing facility with the Director of Maintenance and after completion of the 2013 Edition of the Fire Safety Evaluation System (FSES), it was determined that the facility did achieve a passing score on the second floor of the Steer/Annex building. Findings are as follows: This facility consists of two buildings that are connected together by a connecting corridor where a resident activities room exists. The main building, Mansion, is 4 stories in height with a full basement where sleeping rooms exist on the 1st and 2nd floors. There are no health care occupancies above the 2nd floor, nor is any space above the 2nd floor accessible to residents. The facility utilizes a fire escape on the second floor of the Steere/Annex building as a means of egress which is non-compliant. Upon completion of the FSES on 7/3/2024, the facility did achieve a passing score which deems this citation as compliant. Past Non-compliance date of 6/24/2017.	K 252	Past noncompliance: no plan of correction required.	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Sprinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the	K 351		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415097	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/05/2024

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K 351	Continued From page 9 Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on surveyor observations and staff interviews, it has been determined that the sprinkler system or any of its components does not meet the requirements of installation in accordance with NFPA 101 Life Safety Code 2012 Edition section 9.6 and NFPA 13 Standard for the Installation of Sprinkler Systems 2010 Edition. This deficient practice has the potential to impact 55 of 55 residents as well as an indeterminable number of staff and visitors. Findings are as follows: Record review of the NFPA 13 Standard for the Installation of Sprinkler Systems, 2010 Edition states in part, "...8.5.5.2.1 Continuous or noncontinuous obstruction less than or equal to 18 inches (457 millimeter) below the sprinkler deflector that prevent the pattern from fully developing shall comply with 8.5.5.2... Surveyor observation on 7/2/2024 made during the life safety code tour in the presence of the	K 351	**As a Plan of Correction (POC) for Tag K 351** a) There were no residents named in this citation b) Residents who reside in the facility have the potential to be affected by these findings. c) Storage has been modified to comply with the 18-inch minimum clearance between combustible storage and the sprinkler heads. Where necessary, shelving has been adjusted and signage has been added. We have provided education to all relevant staff. Regular audits will be completed by the Operations Manager or designee to ensure compliance is maintained. d) The Operations Manager is responsible for this plan of correction. The plan of correction will be reviewed by the QAPI committee for at least three months to ensure compliance is achieved. The plan will be revised as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 351	Continued From page 10 Business Operations Associate revealed that the required 18 inch minimum clearance between the combustible storage and the sprinkler heads in the basement storage room were not being properly maintained. During a surveyor interview immediately following the above observations with the Business Operations Associate, he acknowledged that the required 18 inch minimum clearance between the combustible storage and the sprinkler heads in the basement storage room were not being properly maintained.	K 351		