STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415099	A. BUILDING _____ B. WING _____	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE REHABILITATION AND CARE CENTER	999 SOUTH MAIN STREET PASCOAG, RI 02859

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F 000	INITIAL COMMENTS A recertification survey was conducted at Crystal Lake Rehabilitation and Care Center Nursing Home on 4/14/2025 through 4/17/2025 to determine compliance with 42 C.F.R. Part 483, requirements for Long Term Care Facilities. State licensure and emergency preparedness surveys were also conducted at this facility. Deficiencies were identified as a result of this survey.	F 000	This plan of correction is submitted as required under Federal and State regulations and statues applicable to long Term Care providers. This plan of correction does not constitute an admission of liability on the part of the facility and such liability is hereby specifically denied. Th submission of the plan of correction does not constitute an agreement by the facility that the surveyor's findings or conclusions are accurate, and the findings constitute deficiency or that the scope or severity regarding any of the deficiencies cited are correctly applied.	5/7/25
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.	F 582	Received MAY 07 2025 Facilities Regulation	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Margaret Vanasse | TITLE: LNHA | (X6) DATE: 5/7/2025

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 582	Continued From page 1 (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to properly provide notice to residents and/or representatives informing them of when changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan related to the Skilled Nursing Facility Notice of Medicare Non-Coverage (NOMNC), in a timely manner for 3 of 4 residents reviewed who were discharged from a Medicare covered Part A stay with benefit days remaining, Resident ID #s 353, 354, and	F 582	A). Plan of correction for affected residents. Resident ID #353, 354 and 355 had been determined that the facility failed to properly provide notice to the resident and/or representatives informing them of when changes of coverage were made (NOMNC). NOMNC were sent out to each of the above residents. B). Plan of correction to I identify other resident potentially affected by this deficiency. An audit was conducted of residents with coverage changes and no evidence of a NOMNC. NOMNC were sent via email. c). Plan of correction for system changes and measures to prevent recurrence. Medicare/Medicaid and managed care residents and /or responsible party will receive NOMNK 48 hours prior to last covered day (LCD) with an explanation of the Appeal process. Education was provided for MDS coordinator/ Social Worker. D). Plan to monitor effectiveness of corrective action. DNS/MDS or designee will conduct weekly audits on all residents with coverage changes that require a NOMNC's for 4 weeks then monthly there after until compliance is met.	5/7/25

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F 582	Continued From page 2 355. Findings are as follows: Review of the Center for Medicare and Medicaid Services (CMS) Form, CMS-10123, titled, "Form Instructions for the Notice of Medicare Non-Coverage (NOMNC)," states in part, "...A Medicare provider or health plan (Medicare Advantage plans and cost plans, collectively referred to as "plans") must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services. The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily...Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process per Chapter 4, Section 260 of the Medicare Claims Processing Manual and Chapter 13, Sections 90.2-90.9 of the Medicare Managed Care Manual. A NOMNC must be delivered even if the beneficiary agrees with the termination of services..." 1. Record review revealed that Resident ID #353's last covered day of Medicare Part A Services was on 3/13/2025 and s/he was discharged from the facility on 3/14/2025. Further record review failed to reveal evidence that the resident and/or resident representative was issued the NOMNC form. 2. Record review revealed that Resident ID	F 582	Audit findings will be shared/presented in the monthly QAPI meeting X's 3 months or until compliance is achieved.	

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F 582	Continued From page 3 #354's last covered day of Medicare Part A Services was on 3/12/2025 and s/he was discharged from the facility on 3/13/2025. Further record review failed to reveal evidence that the resident and/or resident representative was issued the NOMNC form. 3. Record review revealed that Resident ID #355's last covered day of Medicare Part A Services was on 11/10/2024 and was s/he discharged from the facility on 11/11/2024. Further record review failed to reveal evidence that the resident and/or resident representative was issued the NOMNC form. During a surveyor interview on 4/14/2025 at 2:27 PM, with the Minimum Data Set Coordinator, she acknowledged that Resident ID #s 353, 354, and 355 were not issued a NOMNC form. Additionally, she revealed that she did not know that the form was required when the resident agreed with the discharge. During a surveyor interview on 4/15/2025 at 1:39 PM, with the Administrator, she was unable to provide evidence that the resident and/or resident representative was issued the NOMNC form for Resident ID #s 353, 354, and 355.	F 582		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641	(1). Plan of Correction for affective resident. Accuracy of assessments (smoking) were found to be accurate on residents ID # 10 and 42. Accuracy of assessments(side rails/restraints)	

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F 641	Continued From page 4 Based on record review and staff interview, it has been determined that the facility failed to ensure that the Minimum Data Set (MDS) Assessment accurately reflected the resident's status for 2 of 2 residents reviewed for smoking, Resident ID #s 10 and 42, and 3 of 3 residents reviewed for restraints, Resident ID #s 9, 10, and 31. Findings are as follows: 1. Review of the "Long-Term Care Facility Resident Assessment Instrument [RAI] 3.0 User's Manual" last revised in October 2024 states in part, "...Ask the resident if they used tobacco in any form during the 7-day look-back period. 2. If the resident states that they used tobacco in some form during the 7-day look-back period, code 1, yes. 3. If the resident is unable to answer or indicates that they did not use tobacco of any kind during the look-back period, review the medical record and interview staff for any indication of tobacco use by the resident during the look-back period..." 1a. Record review revealed Resident ID #10 was admitted to the facility in January of 2025 with a diagnosis including, but not limited to, tobacco use. Record review revealed a care plan dated 1/21/2025 which revealed the resident uses a vape (a device used for inhaling vapor containing nicotine and flavoring) and tobacco products. Review of an MDS Assessment dated 1/21/2025, Section J, titled, "Health Conditions" revealed the resident was documented inaccurately as not using tobacco products during the 7-day look-back period.	F 641	residents ID #9, 10, 31, 42. It was found that these residents were coded in error and were modified to reflect the correct assessment. B). Plan of correction to identify other residents potentially for system changes and measures to prevent recurrence. MDS coordinator has been educated on coding process. Audit to ensure resident that smoke and or use sided rails are coded properly, updated and retransmitted for accuracy. C). Plan of correction for systems changes and measures to prevent recurrence. MDS has been educated on proper coding for residents tant smoker and the definition restraint/ side rails. D). Plan of correction to monitor effectiveness of corrective actions. MDS and/or designee will conduct weekly audits on side rail and smoking assessments X's 4 weeks then monthly there after until compliance has been met. Audit findings will be shared/ presented in monthly QAPI meeting X's 3 months or until compliance has been achieved. Responsible party will be the ADM/ DON.	5/1/25

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F 641	Continued From page 5	F 641		

1b. Record review revealed Resident ID #42 was admitted to the facility in September of 2023 with a diagnosis including, but not limited to, type 2 diabetes.

Record review revealed a care plan dated 3/25/2025 which revealed the resident utilizes tobacco products.

Record review revealed a "Smoking Evaluation" dated 3/5/2024, which revealed that the resident utilizes tobacco products.

Review of an MDS Assessment dated 9/26/2025, Section J, titled, "Health Conditions" revealed the resident was documented inaccurately as not using tobacco products during the 7-day look-back period.

2. Review of the RAI Manual dated October 2024 states in part, "...The intent of this section is to record the frequency that the resident was restrained by any of the listed devices or an alarm was used, at any time during the day or night, during the 7-day look-back period. Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definitions in the appropriate categories...DEFINITION PHYSICAL RESTRAINTS Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body..."

2a. Record review revealed Resident ID #9 was admitted to the facility in September of 2024 with

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F 641	Continued From page 6 a diagnosis including, but not limited to, dementia. Record review revealed a physician order dated 2/15/2025 for two 1/4 top side rails as an enabler for bed mobility and transfers, as needed while in bed. Review of an MDS Assessment dated 2/5/2025, Section P, titled, "Restraints" revealed the resident was coded for the use of bed rails as a restraint during the 7-day look-back period. 2b. Record review revealed Resident ID #10 was admitted to the facility in January of 2025 with a diagnosis including, but not limited to, obesity. Record review revealed a physician order dated 2/15/2025 for two 1/4 top side rails as an enabler for bed mobility and transfers as needed while in bed. Review of an MDS Assessment dated 1/21/2025, Section P, titled, "Restraints" revealed the resident was coded for the use of bed rails as a restraint during the 7-day look-back period. 2c. Record review revealed Resident ID #31 was readmitted to the facility in September of 2024 with a diagnosis including, but not limited to, dementia. Record review revealed a physician order dated 2/15/2025 for two 1/4 top side rails as an enabler for bed mobility and transfers, as needed while in bed. Review of an MDS Assessment dated 3/18/2025, Section P, titled, "Restraints" revealed the	F 641		

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F 641	Continued From page 7 resident was coded for the use of a bed rails as a restraint during the 7-day look-back period. During surveyor interviews on 4/16/2025 at 10:28 AM and 4/17/2025 at 10:43 AM, with the MDS Coordinator, she revealed that Resident ID #s 10 and 42 are active smokers and utilize tobacco products. Additionally, she revealed that Resident ID #s 9, 10, and 31 utilize the side rails for bed mobility and transfers, but that they are not utilized as a restraint and do not meet the definition of a restraint. Furthermore, she revealed that the MDS Assessments for Resident ID #s 9,10, 31, and 42 were coded in error and would be modified with the correct information, after being brought to the facility's attention by the surveyor. During a surveyor interview on 4/17/2025 at 10:43 AM, with the Director of Nursing Services, she acknowledged that the above MDS assessments for Resident ID #s 9, 10, 31, and 42 were coded inaccurately.	F 641		
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. 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 services being provided meet professional standards of practice relative to insulin administration for 1 of 3 residents reviewed,	F 658	(1). Plan of correction for affected resident. Resident ID #42, medical record revealed that insulin Lispro was noted administered (held) as ordered due to low blood sugar without parameters. MD has been notified. (2). Plan of correction to identify potential affected residents by this deficiency. Residents with insulin orders were identified. Medical records for insulin administration were reviewed.	

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F 658	Continued From page 8 Resident ID #42. 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 that the resident was admitted to the facility in September of 2023 with a diagnosis including, but not limited to, type II diabetes. Record review revealed the following physician's orders: - Insulin lispro (fast-acting insulin that starts to work about 15 minutes after injection) 100 units/ milliliter (ml), administer 3 units subcutaneously (the layer of tissue just below the skin) daily from 11:30 AM until 1:00 PM. - Insulin lispro 100 units/mL, administer 3 units subcutaneous daily from 4:30 PM until 6:00 PM - Insulin lispro 100 units/mL, administer 3 units subcutaneous from 4:00 PM until 6:30 PM. Record review revealed that on the following dates and times, the insulin lispro was not administered as ordered: - 4/7/2025 from 4:30 PM until 6:00 PM, with a documented blood sugar of 83 milligrams (mg)/ deciliter (dL)	F 658	Audit was conducted for compliance. C). Plan of correction for system changes and measures to prevent recurrence. License nursing staff have been educated on holding insulin without parameters and reporting to the MD. D). Plan of correction for monitoring weekly audits. DONand/or designee will conduct weekly audits on residents with insulin orders 's 4weeks then monthly there after until compliance is met. Audit findings will be shared/ presented in monthly QAPI meeting X's 3 months or until compliance is achieved. Responsible party will be Adm./DNS	5/7/25

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F 658	Continued From page 9 - 4/11/2025 from 11:30 AM until 1:00 PM, with a documented blood sugar of 71 mg/dL - 4/14/2025 from 4:00 PM until 5:30 PM, with a documented blood sugar of 88 mg/dL Record review failed to reveal evidence that the provider was notified of the insulin lispro not being administered on 4/7, 4/11 or 4/14/2025. During a surveyor interview on 4/16/2025 at 10:38 AM with Licensed Practical Nurse, Staff A, she revealed that there are no parameters to hold the insulin in the order. Additionally, she revealed that the insulin should be given during the meal and if the medication was held, it should be reported to the provider. During a surveyor interview on 4/16/2025 at 10:34 AM with the Director of Nursing Services, she was unable to provide evidence that the insulin lispro was administered, as ordered, on 4/7/2025, 4/11/2025 and 4/14/2025. During a surveyor interview on 4/16/2025 at 10:49 AM with the Nurse Practitioner, Staff B, she revealed that she would expect the staff to follow the order as written and if the medication is held, she would expect the staff to notify her.	F 658		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		

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

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F 684	Continued From page 10 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, it has been determined that the facility failed to ensure that each resident receives the necessary care and services to attain or maintain the highest practicable physical well-being for 1 of 2 residents reviewed for appointments, Resident ID #25. Findings are as follows: Record review revealed that Resident ID #25 was admitted to the facility in August of 2024 with diagnoses including, but not limited to, adult failure to thrive and repeated falls. Record review revealed a physician's order dated 1/27/2025 to obtain a neurology consult. Review of the progress notes revealed the following: - 1/27/2025 the resident's diagnoses were reviewed by the Nurse Practitioner (NP), Staff B, and a new order was obtained for a neurology consult - 1/27/2025 authored by Staff B, which revealed that speech therapy was to see the resident due to increase tremors and trouble swallowing, as well as his/her diet had been downgraded to a chopped texture with thin liquids. Additionally, a neurology consult was placed for tremors and dysphagia, (difficulty swallowing) with concerns for Parkinson's disease versus medication	F 684	A).Plan of correction for effected resident. Resident ID #25 medical record revealed a physician's order dated 1/27/2025 to obtain a neurology consult due to reported tremors and dysphagia. Records failed to show evidence of an appointment with a Neurologist. Information has been faxed to Brown Neurology. B). Plan of correction to identify other residents potentially affected by this deficiency. An audit was done on current residents medical records to determine if any other residents were affected. C). Plan of System Changes and measures to prevent recurrence. Follow up appointment slips are available at the nurses station, nursing staff have been educated on appointment procedures. D). Plan of correction to monitor effectiveness of corrective actions. DON and/or designee will conduct weekly audit on appointments/follow ups X 4 weeks then monthly there after until compliance has been met. Audit findings will be shared/presented in monthly QAPI meeting X's 3 months or until compliance is achieved. Responsible party will be DON or designee.	5/7/25

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F 684	Continued From page 11 induced tremors - 4/10/2025 revealed the resident had upper extremity tremors with holding objects most of the time Review a document titled, "Occupational Therapy Treatment Encounter Note(s)" dated 1/29/2025, revealed that the resident complained of bilateral hand tremors and complained of having difficulty with drinking with a regular cup. Record review failed to reveal evidence that a neurology consult appointment was scheduled, attended, or declined by the resident. Review of the transport calendar for the year of 2025, with the Administrator, failed to reveal evidence that a neurology consult appointment was scheduled for Resident ID #25. During a surveyor interview on 4/16/2025 at 11:00 AM with Licensed Practical Nurse, Staff A, she revealed that she was unable to find evidence that the neurology appointment was scheduled, attended, or declined by the resident. During a surveyor interview on 4/16/2025 at 11:18 AM, with the Director of Nursing Services (DNS), she revealed that the person in charge of setting up appointments for the residents was unaware that Resident ID #25 was ordered or needed a neurology consult appointment. During a surveyor interview and observation on 4/16/2025 at 11:25 AM, with the resident, in the presence of the DNS, the resident was observed to have tremors. Additionally, the resident revealed that s/he did not decline an appointment	F 684		

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	415099	A. BUILDING _____ B. WING _____	04/17/2025

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F 684	Continued From page 12 for a neurology consult. Furthermore, s/he revealed to the DNS and the surveyor that s/he was still having tremors and still needs to attend the neurology consult. During a surveyor interview on 4/18/2025 at approximately 12:30 PM with the DNS, in the presence of the Administrator, she was unable to provide evidence that the facility followed up and scheduled the neurology appointment as ordered by the provider on 1/27/2026.	F 684		
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 store, prepare, distribute, and serve food	F 812	(1) Plan of correction for ice machine that had visible dirty components. Ice machine visible components have been cleaned and debris has been removed. The Kitchen aid appliance has been discarded as it was not in good working order. The exterior of the exhaust hood has been cleaned and the bi-annual cleaning has been done by AAA Restaurant Fire Control on 4/22/2025. (2). No residents were identified in the deficient practice. (3). Plan of correction for system changes and measures to prevent recurrence. The food service manager has developed a cleaning schedule to eliminate these issues in the future. (4) Plan of correction to monitor effective ness of corrective actions.	5/1/25

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F 812	Continued From page 13 In accordance with professional standards for food service safety, relative to the main kitchen. Findings are as follows: Review of the Rhode Island Food Code 2018 Edition 4-601.11, states in part, "...Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." During surveyor observations on the initial tour of the main kitchen on 4/14/2025 at approximately 9:15 AM, in the presence of the Food Service Director (FSD), revealed the following: - A white colored component within the ice machine noted with black and pink matter, that was able to be removed by wiping it with a paper towel - A Kitchen Aid® appliance covered with a clear plastic bag, with a dark brown liquid matter leaking from a seam on the upper portion of the appliance onto the bag and appliance itself - An accumulation of a grease-like residue on the exhaust hoods above the stove and griddle. Additionally, a sticker was observed indicating that the hoods were last cleaned on 11/11/2024 During a surveyor interview immediately following the above observations on 4/14/2025 with the FSD, he acknowledged the discolored wipeable matter within the ice machine, the discolored liquid matter leaking from the kitchen appliance, and the grease-like accumulation on the exhaust hoods and indicated that they should be cleaned.	F 812	Audits will be conducted on a routine basis by the food service director and/or a designee. The results will be presented/discussed at the monthly QAPI meetings for 3 months or until compliance is achieved. The Administrator is responsible for the implementation of the cleaning program.	

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F 838 F 838 SS=F	Continued From page 14 Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and	F 838 F 838 EM 5/9/25	(1). Plan of correction for the observation of the facility assessment. The facility assessment was found to be incomplete according to the new guidelines and regulations. (2). There were no residents directly affected by this deficiency. (3) Plan of Correction for system changes and measures to prevent recurrence. The Administrator has obtained a template for the updated process and will complete it accordingly. All disciplines, residents, resident representatives, and familiy members will be represented in development of this plan.	5/17/25

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F 838	Continued From page 15 (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management,	F 838		

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F 838	Continued From page 16 including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse	F 838		

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F 838	Continued From page 17 staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies which must be reviewed and updated as necessary, and at least annually. Findings are as follows: 1. Record review revealed a document titled, "Facility Assessment" last updated 3/10/2025, which revealed the following participants were involved in the completion of the Facility Assessment: - Administrator - Director of Nursing Services - Director of Environmental Services - Medical Director Record review failed to reveal evidence of the involvement of direct care staff including, but not limited to, Registered Nurse, Licensed Practical Nurse, Nursing Assistant, or a representative of the direct care staff, in the completion of the Facility Assessment. Further review of the "Facility Assessment" failed to reveal evidence that the facility solicited and considered input received from the residents, resident representatives, and family members. 2. Review of the "Facility Assessment" failed to	F 838		

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F 838	Continued From page 18 reveal evidence that the facility developed and maintained a plan to maximize recruitment and retention of direct care staff. During a surveyor interview on 4/17/2025 at 10:50 AM, with the Administrator, she revealed that direct care staff, residents, family, or resident representatives were not involved in the completion of the Facility Assessment. Further, she acknowledged that the Facility Assessment did not include a plan to maximize recruitment and retention of direct care staff, per the regulation.	F 838		

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by the Center for Health Facilities and Regulation on 4/14/2025. The facility was found to be in compliance with 42 CFR §483.73 related to Emergency Preparedness. Capacity: 71 Census: 47	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Margaret Vaccaro | TITLE: LNHA | (X6) DATE: 5/7/25

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 4/15/2025. Crystal Lake Rehabilitation and Care 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: 71 Census: 47	K 000	This plan of correction is submitted as required under Federal and State regulations and statuses applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and such liability is hereby specifically denied. This submission of the plan of correction does not constitute an agreement by the facility that the surveyor's findings or conclusions are accurate, and the findings constitute deficiency or that the scope or severity regarding any of the deficiencies cited are correctly applied.	
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined that the facility failed to maintain the means of egress free of all obstructions in case of an emergency in accordance with National Fire Protection Association (NFPA) 101 2012 edition Chapter 7, unless modified by 19.2.2 through 19.2.11, 19.2.1, 7.1.10.1. This deficient practice has the potential to impact 47 of 47 residents as well as	K 211		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Margaret Vacuso	LNHA	5/7/2025

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K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on surveyor observation and staff interview, it has been determined that the facility failed to maintain the means of egress free of all obstructions in case of an emergency in accordance with National Fire Protection Association (NFPA) 101 2012 edition Chapter 7, unless modified by 19.2.2 through 19.2.11, 19.2.1, 7.1.10.1. This deficient practice has the potential to impact 47 of 47 residents as well as	K 211		

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K 211	Continued From page 1 an indeterminable number of staff and visitors. Findings are as follows: Review of NFPA 101 2012 edition states in part, " ...19.2.4 Number of Means of Egress. 19.2.4.1 The number of means of egress shall be in accordance with 7.4.1.1 and 7.4.1.3 through 7.4.1.6. 19.2.4.2 Not less than two exits shall be provided on every story. 19.2.4.3 Not less than two separate exits shall be accessible from every part of every story. 7.1.10.1* General. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency..." Surveyor observation on 4/15/2025 at approximately 1:25 PM, in the presence of the Maintenance Director, revealed that the hallway from the rehabilitation room door to the exit door had construction supplies and furniture in the path of egress. During a surveyor interview with the Maintenance Director on 4/15/2025 at the time of the above-mentioned observation, he acknowledged that there were construction supplies and furniture in the path of egress.	K 211	(1). All items obstructing the exit were immediately removed by maintenance. (2). Maintenance will do daily checks for continued compliance. (3). Signage will be made to ensure compliance. (4). The Administrator/ Designee will monitor frequently for safety of our residents. (1). The fire doors have all been inspected per code and there were no difficient doors noted	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		

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K 761	Continued From page 2 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on surveyor observation, staff interview, and record review, it has been determined that the facility failed to ensure that the smoke and fire doors are being maintained in accordance with the National Fire Protection Association (NFPA) 101 Life Safety Code, 2012 Edition. This deficient practice could impact 47 of 47 residents, as well as an indeterminable number of staff and visitors. Findings are as follows: Record review of NFPA 101 Life Safety Code, 2012 Edition, states in part, "...7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.6: (1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7 (2) Door assemblies in exit enclosures (3) Electrically controlled egress doors	K 761	(3) The Administrator will approve this process and follow up on the timeliness of the inspections. (4). This will be added to the QAPI program to be sure this is done timely.	

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	415099	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL LAKE REHABILITATION AND CARE CENTER	989 SOUTH MAIN STREET PASCOAG, RI 02859

(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 761	Continued From page 3 (4) Door assemblies with special locking arrangements subject to 7.2.1.6..." Record review of the smoke and fire door maintenance records on 4/14/2025, failed to reveal evidence that the fire and smoke doors were tested and inspected annually, as required. During a surveyor interview with the Maintenance Director on 4/15/2025 at 1:45 PM, he was unable to provide evidence that the smoke and fire doors were being inspected and tested annually, as required.	K 761		