STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415061	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Health Center	4000 Post Road , Warwick, Rhode Island, 02886

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F0000	INITIAL COMMENTS A recertification and complaint surveys, Intake ID reference numbers 200268, 200235, 200276, 2567467, and 2571491, were conducted at Brentwood Health Center on 7/22/2025 through 7/25/2025 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. Census: 88	F0000	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. In-services have been underway and are ongoing. We are alleging compliance effective August 24, 2025.	
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph	F0580	**As a Plan of Correction (POC) for Tag F580:** a) Resident ID#8 has since returned to our facility after hospitalization for the noted change in condition indicated on the 2567. We have parted ways with Staff A. b) We recognize that all residents may be at risk for a change in condition and that the MD must be notified of said changes timely. We have since reviewed all residents to ensure that any clinical changes in condition that any resident may be experiencing has been communicated to the Attending MD timely.	

Received
AUG 13 2025
Facilities Regulation

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Admin	8-13-25

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F0580 SS = D	Continued from page 1 (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to immediately inform the resident's physician of his/her change of condition, which resulted in the transfer of the resident to an acute care hospital for 1 of 4 residents reviewed, Resident ID #8. Findings are as follows: Record review of a facility reported incident submitted to the Rhode Island Department of Health on 7/20/2025 states in part, "...Incident of unknown origin...facility informed...about an injury of fractured ribs and lacerated spleen...Family and MD [medical doctor] all aware. Investigation to be completed." Record review of a community reported complaint submitted to the Rhode Island Department of Health on 7/25/2025 alleges in part, that the resident arrived at	F0580	c) The nursing leadership team is providing the nurses, CNAs, and CMTs of the policies and regulations regarding notification of changes in condition to the Provider. The education will include examples of changes in condition and the requirements to assess, document and notify the Provider timely. We will discuss residents with changes in condition at our morning meetings and weekly Risk meetings to ensure adequate assessment has been documented and to confirm evidence of notification to the Provider of these changes. d) The Director of Nursing (DNS)/designee is responsible for executing this improvement plan. The audits results of those residents with changes in condition will be shared with the QAPI Committee each month for a period of no less than 3 months at which time we will re-evaluate our progress and improvement. The QAPI Committee will determine the need/frequency to continue the formal auditing based on our level of improvement.	

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F0580 SS = D	Continued from page 2 the hospital after a suspected unwitnessed fall. S/he had bruising on left flank, a grade 4 splenic laceration (classified as a severe injury involving significant vascular injury and active bleeding), and displaced fractures of the left 10th and 11th ribs. Record review of a facility policy dated 10/17/2023 titled "Resident Change in Condition" states in part, "...Changes in condition require assessment by the Nurse and notification to the MD (both to be done timely). "Timely" depends upon the level/severity of the change and the Nurse should use professional assessment and judgment to make that decision. Timely is certainly no later than the shift of the change..." Record review revealed the resident was re-admitted to the facility in June of 2025 with a diagnosis including, but not limited to, sepsis (a systemic infection that can to tissue damage, organ failure and possible death). Record review of the resident's progress note dated 7/20/2025 at 7:52 AM authored by third shift, Licensed Practical Nurse (LPN), Staff A, revealed that the resident was found by the nursing assistant in bed "full of watery stool from head to toe" at 6:00 AM and his/her vital signs were obtained which revealed, respirations of 24 (normal range 12-16), pulse oximetry of 77% (a normal oxygen saturation level ranges between 95% to 100%; a low reading below 95% increases the risk of damage to your tissues and organs), and a blood pressure of 98/58 (normal blood pressure is 120/80). Further record review of the progress notes dated 7/20/2025 at 7:30 AM authored by first shift, Registered Nurse (RN), Staff B, revealed that upon his arrival, the resident was found to be moaning and not responding. The resident was placed on 2 liters of oxygen via nasal cannula (a medical device that provides supplemental oxygen therapy to people who have lower oxygen levels) due to an oxygen saturation of 77%, emergency medical services arrived and the resident was transported to the emergency department. During a surveyor interview on 7/24/2025 at 10:07 AM with Staff A, he revealed that at approximately 5:00 AM, a nursing assistant notified him that the resident was found in bed with a large amount of watery stools. He further indicated that he later went in to administer a medication to the resident "a little after 5:00 AM," and the resident was observed to be "uncomfortable, restless and kicking [his/her] arms and lifting [his/her] hips off of the bed." Additionally, he revealed that he asked RN, Staff C, to assist him	F0580		

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F0580 SS = D	Continued from page 3 with the resident around 5:30 AM – 5:45 AM. He further revealed that Staff C instructed him to call the provider, but he was unable to do so, as the tablet did not work. During a surveyor interview on 7/24/2025 at approximately 11:00 AM with Staff C, she revealed that Staff A came down to get her to "look at [Resident ID #8] around 6:00 AM" because s/he was restless and kept moving his/her arms and lifting his/her knees up. Additionally, she revealed that she was unaware that Staff A did not notify the on-call provider. During a surveyor interview on 7/24/2025 at 11:10 AM with the resident's medical doctor, Staff D, he revealed that he would expect the staff to call him if they were unable to contact the on-call provider related to the resident's change in condition. During a surveyor interview on 7/25/2025 at 11:35 AM with the Director Nursing Services and the Assistant Director of Nursing Services, they were unable to provide evidence that the resident's provider was immediately notified of his/her change in condition until the day shift nurse Staff B arrived for his shift at 7:00 AM, which was approximately two hours after the initial change in condition was identified. Record review of an "RI EMS [Rhode Island emergency medical services] Patient care report" revealed that dispatch was notified at 7:34 AM and the unit was dispatched to the facility at 7:36 AM. Additionally, the report revealed upon EMS arrival that the resident was lying in bed unresponsive with left and right-side weakness. Cross reference F 658, F 684, F 690, F 726.	F0580		
F0658 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 provided by the facility meet professional	F0658	**As a POC for Tag F658:** a) Resident ID#8 has since returned to our facility after hospitalization for the noted change in condition indicated on the 2567. We have parted ways with Staff A. Residents ID#16, 29, and 75 have been reweighed and we are following the policy related to weight monitoring.	

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F0658 SS = D	Continued from page 4 standards of quality relative to following physician's orders for 1 of 4 residents reviewed related to oxygen utilization, for 1 of 1 resident reviewed relative to orthostatic blood pressure (measurements of blood pressure taken while a patient is in different positions), Resident ID #8, and for 3 of 7 residents reviewed relative to weight discrepancies, Resident ID #s 16, 29, and 75. Findings are as follows: According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, "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." 1. Record review of a facility reported incident submitted to the Rhode Island Department of Health on 7/20/2025 states in part, "...Incident of unknown origin...facility informed...about an injury of fractured ribs and lacerated spleen...Family and MD [medical doctor] all aware, investigation to be completed." Record review of a community reported complaint submitted to the Rhode Island Department of Health on 7/25/2025 alleges in part, that the resident arrived at the hospital after a suspected unwitnessed fall. S/he had bruising on left flank, a grade 4 splenic laceration (classified as a severe injury involving significant vascular injury and active bleeding), and displaced fractures of the left 10th and 11th ribs. Record review revealed that Resident ID #8 was re-admitted to the facility in June of 2025 with a diagnosis including, but not limited to, sepsis (a systemic infection that can to tissue damage, organ failure and possible death). a. Record review revealed a physician's order dated 1/28/2025 to administer oxygen 1 to 4 liters per minute via nasal cannula (a medical device that provides supplemental oxygen therapy to people who have lower oxygen levels) as needed. During a surveyor interview on 7/24/2025 at 10:07 AM with Licensed Practical Nurse (LPN) Staff A, he revealed that he went in to administer a medication to Resident ID #8 "a little after 5:00 AM." Resident ID #8 was observed to be "uncomfortable, restless and kicking [his/her] arms and lifting [his/her] hips off of the bed." Additionally, Staff A, revealed that he was able to obtain pulse oximetry readings (used to monitor arterial oxygen saturation non-invasively) of 79% and	F0658	b) We recognize that all residents may be at risk for negative outcomes if/when MD orders are not followed precisely (such as oxygen delivery, orthostatic blood pressures being carried out and/or weights being monitored routinely). We have since reviewed all residents with any of these orders in place for assurances that these MD orders are being executed. We have responded accordingly to any occurrences that required our intervention/follow-up. c) The nursing management team are re-educating the nurses regarding the importance of executing MD orders timely and as directed in the order. We are reviewing all residents with orders for oxygen to ensure administration of the oxygen ordered per resident need. We are reviewing all residents with orders for orthostatic blood pressures for assurances they are being completed and reported to the MD timely. We are reviewing the weights for all residents to ensure the policy regarding reweighs is being followed and weights obtained timely (with discrepancies responded to per policy with timely notification to MD). All of these care areas will be reviewed at our weekly Risk meetings and monitored through our QAPI program. d) The Director of Nursing (DNS)/designee is responsible for ensuring this action plan is executed timely. We are conducting audits of MD orders specific to oxygen, orthostatic blood pressures, and weights to confirm follow through and proper response. These results will be shared with the QAPI Committee monthly for at least 3 months, after which time, the Committee will re-evaluate the need to formally monitor the issue based on our level of compliance and improvement in both areas of professional standards.	

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F0658 SS = D	Continued from page 5 84% (a normal oxygen saturation [SpO2] level range is between 95% to 100%; a reading below 95% increases the risk of damage to your tissues and organs) for the resident. When questioned by the surveyor why oxygen was not administered to the resident when the resident had an SpO2 readings of 79% and 84% indicating that s/he was hypoxic (low blood oxygen level), Staff A was unable to answer and acknowledged that the oxygen was not administered as ordered. b. According to Jensen's Fourth Edition, Nursing Health Assessment, page 118 states, "Orthostatic vital signs are measured in patients to assess for a drop in BP [blood pressure]...with position changes...Some medications can have the adverse effect causing orthostatic hypotension...Assess BP...with the patient [lying], sitting, and standing...waiting 1-2 minutes after each position change to assess the readings...Drop in SBP [systolic blood pressure] of 15 mmHg [millimeters of mercury] or greater, drop of DBP [diastolic blood pressure] of 10 mmHg or greater...indicates orthostatic hypotension..." Record review revealed a physician's order dated 7/15/2025 to obtain orthostatic blood pressures once a day for 3 days then weekly for four weeks. Review of the July 2025 Medication Administration Record from 7/15/2025 to 7/20/2025 failed to reveal evidence that orthostatic blood pressures were obtained. During a surveyor interview on 7/24/2025 at approximately 2:10 PM with the Director of Nursing Services (DNS), she was unable to provide evidence that the physician's orders were followed for Resident ID #8 for the utilization of oxygen when needed and that orthostatic blood pressures were obtained. 2. Review of the facility policy titled, "Weight Loss/Gain Protocol..." revealed the following: -The resident will be weighed on the day of admission -The resident will then be weighed weekly for three weeks and after the first four weeks of admission, the frequency of weights will then be decided by the interdisciplinary team. -A significant weight discrepancy is defined as:A weight change of 3 pounds or more in one weekA loss/gain of 5% or greater in one month.-When a significant weight loss/gain is noted, a reweigh shall be done within 48 hours of the initial weight.	F0658		

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F0658 SS = D	Continued from page 6 -If the reweigh is accurate and there has been a significant weight loss/gain, nursing must notify the physician, dietician, DNS, and the resident representative. a. Record review revealed that Resident ID #16 was admitted to the facility in July of 2025 with a diagnosis including, but not limited to, Type II diabetes mellitus. Record review of the resident's weights revealed the following: -7/14/2025 188.5 lbs. (pounds) -7/20/2025 155.8 lbs. (32.7 lbs. difference with no evidence of reweigh) Further record review failed to reveal evidence that a reweigh was completed until it was brought to the facility's attention by the surveyor on 7/24/2025. During a surveyor interview on 7/24/2025 at 1:14 PM with Licensed Practical Nurse (LPN), Staff E, she indicated that the residents are weighed on admission but if there is an admission weight discrepancy, a reweigh must be obtained. She acknowledged that there was no reweigh on 7/20/2025, and that she would have expected the staff to have reweighed the resident on that day or the next day. During a surveyor interview on 7/25/2025 at approximately 1:00 PM with the Dietitian, she acknowledged that she noted the 32.7 lbs. weight discrepancy and had requested a reweigh to be obtained for Resident ID #16. However, she acknowledged the weight was not obtained until it was brought to the facility's attention by the surveyor on 7/24/2025. b. Record review revealed Resident ID #29 was readmitted to the facility in July of 2025 with a diagnosis including, but not limited to, urinary tract infection. Review of the resident's weights revealed the following: -7/10/2025 weight 207 lbs. -7/15/2025 weight 215.5 lbs. (8.5 lbs. difference with no evidence of reweigh) -7/22/2025 weight 211.8 lbs. (3.7 lbs. difference with	F0658		

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F0658 SS = D	Continued from page 7 no evidence of reweigh) During a surveyor interview on 7/25/2025 at 11:02 AM with LPN, Staff F, she acknowledged that she entered the 215.5 lbs. weight on 7/15/2025 but did not reweigh the resident. c. Record review revealed Resident ID #75 was admitted to the facility in December of 2022 with a diagnosis including, but not limited to, abnormal weight loss. Review of the resident's weights revealed the following: -6/17/2025 weight 193.6 lbs. -6/24/2025 weight 197.4 lbs. (3.8 lbs. discrepancy with no evidence of reweigh) -7/8/2025 – weight 197.5 lbs. -7/22/2025 – weight 190.6 lbs. (6.9 lbs. discrepancy with no evidence of reweigh) During a surveyor interview on 7/25/2025 at 12:44 PM with the Dietitian, she acknowledged the weight discrepancies but indicated she was not notified by nursing staff. She indicated that the resident should have been reweighed after the 190.6 lbs. weight documented on 7/22/2025. During a surveyor interview on 7/25/2025 at 11:19 AM and 2:09 PM with the Director of Nursing Services, she indicated that it would be her expectation that when a weight discrepancy is identified, a reweigh will be obtained. Cross reference F 580, F 684, F 690 and F 726.	F0658		
F0684 SS = D	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 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by:	F0684	**As a POC for F684:** a) Resident ID#8 is being reviewed at our weekly Risk meeting so as to ensure we are following through with all MD orders and responding accordingly to any changes in condition. [illegible]	

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F0684 SS = D	Continued from page 8 Based on record review and staff interview, it has been determined that the facility failed to provide the necessary treatment and care in accordance with professional standards of practice relative to obtaining orthostatic vital signs per a physician's order, identifying a change in a resident's condition and physician notification, for 1 of 1 resident reviewed for hospitalization, Resident ID #8. 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 that the orders are in error or would harm the clients." According to Jensen's Fourth Edition, Nursing Health Assessment, page 118 states, "Orthostatic vital signs are measured in patients to assess for a drop in BP [blood pressure]...with position changes...Some medications can have the adverse effect causing orthostatic hypotension...Assess BP...with the patient [lying], sitting, and standing...waiting 1-2 minutes after each position change to assess the readings...Drop in SBP [systolic blood pressure] of 15 mmHg [millimeters of mercury] or greater, drop of DBP [diastolic blood pressure] of 10 mmHg or greater...Indicates orthostatic hypotension..." Record review of a facility reported incident submitted to the Rhode Island Department of Health on 7/20/2025 states in part, "...Incident of unknown origin...facility informed...about an injury of fractured ribs and lacerated spleen...Family and MD [medical doctor] all aware, investigation to be completed." Record review of a community reported complaint submitted to the Rhode Island Department of Health on 7/26/2025 alleges in part, that the resident arrived at the hospital after a suspected unwitnessed fall. S/he had bruising on the left flank, a grade 4 splenic laceration (classified as a severe injury involving significant vascular injury and active bleeding), and displaced fractures of the left 10th and 11th ribs. Record review revealed the resident was re-admitted to	F0684	b) We have since reviewed all residents at risk to fall to ensure their care plan interventions and any MD orders related to fall interventions are being executed accordingly and timely. We are responding to any concerns identified during our reviews. c) The nurses are receiving re-education regarding following through with MD orders and timely execution of interventions related to fall reduction. We are reviewing MD orders related to falls to confirm they are being carried out as ordered. Those residents with orders for orthostatic blood pressures are also being reviewed. The IDT will be reviewing residents at risk for falls at our weekly Risk meeting, to ensure the care plan interventions are updated timely (and executed) and any MD orders related to falls and/or changes in condition are carried out and document accordingly. d) The DNS/designee is responsible for ensuring this action plan is executed timely. We are conducting audits residents at risk to fall to confirm MD orders and care plan interventions are carried out. These audit results will be shared with the QAPI Committee monthly for at least 3 months, after which time, the Committee will re-evaluate the need to formally monitor the issue based on our level of compliance and improvement.	

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F0684 SS = D	Continued from page 9 the facility in June of 2025 with a diagnosis including, but not limited to, sepsis (a systemic infection that can lead to tissue damage, organ failure and even death). Record review of the care plan last revised on 7/21/2025 with a focus area indicating the resident has a history of falling and is at risk of future falls with interventions including, but not limited to, orthostatic vital sign monitoring (measurements of blood pressure and heart rate taken while a patient is in different positions, primarily to assess for orthostatic hypotension and other cardiovascular issues) due to the use of Seroquel (an antipsychotic medication) and update the physician or nurse practitioner (NP) with changes as needed. 1.Record review of the progress notes revealed that the resident sustained falls on the following dates: -7/13/2025 found kneeling in front of the sink -7/13/2025 resident noted on the floor in the middle of his/her room -7/14/2025 found on the floor of his/her bathroom -7/14/2025 resident was found kneeling next to his/her bed Record review revealed a physician's order to monitor the resident's orthostatic blood pressure daily for three days dated 7/15/2025 with a discontinue date of 7/17/2025, then weekly for four weeks. Review of the July 2025 Medication Administration Record failed to reveal evidence that orthostatic blood pressures were obtained, as ordered. During a surveyor interview on 7/24/2025 at 11:30 AM with the Director Nursing Services, she was unable to provide evidence that the orthostatic blood pressures were obtained for Resident ID #8.	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415061	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0684 SS = D	Continued from page 10 Cross reference F 580, F 690, F 726.	F0684		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to provide the appropriate treatment and services for 1 of 1 resident reviewed for constipation, Resident ID #8. Findings are as follows: Review of the facility policy titled, "Bowel function management", states in part, "it is the policy of this facility to manage each resident's bowel function in	F0690	**As a POC for Tag F690:** a) Resident ID#8 has returned to our facility after a hospital stay. We are monitoring Resident ID#8's bowel function carefully. b) We recognize all residents are at risk for a similar situation regarding inadequate monitoring of bowel function and we are reviewing all residents bowel function to ensure proper documentation of bowel elimination. We are responding accordingly to any issues requiring our intervention. c) The nurses, CNAs and CMTs are being re-educated regarding the policy related to monitoring bowel functioning/elimination. We are also re-educating the care team on the proper way to document bowel elimination and the need to review this daily. Nursing management will review bowel elimination routinely to ensure the policy, protocol and/or resident-specific orders for laxatives are being executed properly and timely. d) The DNS/designee is responsible for executing this action plan. Routine review and auditing of bowel elimination per resident will be done. All observation/audit results will be shared with the QAPI Committee each month for a period of 3 months after which time, the QAPI Committee will evaluate our level of improvement and determine the need/frequency at which to continue or discontinue the formal audits.	

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F0690 SS = D	Continued from page 11 order to promote regular, voluntary, controlled bowel evacuation of normal consistency. Normal bowel function involves passage of soft, formed stools in adequate volumes without straining...Every resident's bowel function is to be monitored every day on every shift...The charge nurse is responsible to monitor the resident's bowel activity daily...Interventions to promote adequate bowel function: 1. Determine the resident's bowel function by regular review of the bowel documentation...Assess the success of the...interventions..." Record review revealed the resident was readmitted to the facility in June of 2025 with a diagnosis including, but not limited to, sepsis (a systemic infection that can cause tissue damage, organ failure, and possible death), constipation. Review of the bowel records failed to reveal evidence that the resident had a bowel movement from 7/9/2025 through 7/13/2025, indicating that s/he did not have a bowel movement for 5 days. Record review failed to reveal evidence that the physician was notified of the resident's lack of bowel movements over the 5-day time period. During a surveyor interview on 7/25/2025 at 1:52 PM with Nurse Practitioner, Staff G, she indicated that she would expect to be notified when a resident went without a bowel movement for three days for further interventions. During a surveyor interview on 7/25/2025 at 2:20 PM with the Director of Nursing Services, she revealed that it would be her expectation that nursing staff would contact the provider if a resident went without a bowel movement for three days for further interventions. Cross reference F 580, F 658, F 684 and F 726.	F0690		
F0726 SS = D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(d) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each	F0726	**As a POC for Tag F726:** a) Resident ID#8 has since returned to our facility after hospitalization for the noted change in condition indicated on the 2567. We have parted ways with Staff A.	

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F0726 SS = D	Continued from page 12 resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(d) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of 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 ensure that staff were competent to provide nursing and related services to assure resident safety to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident, as the facility staff were unable to identify a change in condition, administer oxygen in the setting of hypoxia (low blood oxygen level), document accurately, and administering medications as ordered for one of four residents reviewed, Resident ID #8. Findings are as follows: 1.Record review revealed Resident #8 was re-admitted to the facility in June of 2025 with a diagnosis including, but not limited to, sepsis (a systemic infection that can lead to tissue damage, organ failure and possible death). Record review revealed a physician's order dated 1/28/2025 to administer oxygen at 1-4 liters per minute via nasal cannula (a medical device that provides	F0726	b) We recognize all residents are at risk of not receiving a proper assessment and other care needs if the nurses are not competent. We have since reviewed all residents to confirm they are stable and their clinical needs being met. c) The nurses are receiving competency-based training on clinical assessment, documentation standards, medication administration safety, and professional code of conduct. This training will be conducted now and again before the end of 2025. We will include all of this competency based training into our training program for 2026 as well. Nurses who do not perform according to expected standards will be disciplined accordingly and released from their employment with us if necessary. d) The DNS/designee is responsible for executing this plan. The competency-based training completion per nurses will be shared with the QAPI Committee who will review each nurses education packet for assurances they have all been completed and passed. The Committee will review this through 2025 and then determine the need/frequency to confit their formal review process.	

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F0726 SS = D	Continued from page 13 supplemental oxygen therapy to people who have lower oxygen levels) as needed for shortness of breath or hypoxia (low blood oxygen level). Record review of a nursing progress note dated 7/20/2025 at 7:52 AM states in part, "0600 upon am rounds, resident was found by cna [Certified Nursing Assistant] in bed full of watery stool from head to toe. Resident was washed up and bed changed. Resident seems to be agitated and thrashing around in bed. VS [vital signs] obtained, and temp [temperature] was 98.4 [F], Resp [respirations] 24 [normal range 12-16], BP [blood pressure] 98/58 [normal blood pressure is 120/80], not a perfect bp due to resident thrashing around. [oxygen saturation, SpO2] @ [at] 77% [a normal SpO2 level ranges between 95% to 100%; a reading below 95% increases the risk of damage to your tissues and organs] .." During a surveyor interview on 7/24/2025 at 10:07 AM with Licensed Practical Nurse (LPN), Staff A, he revealed that he went in to administer a medication to Resident ID #8 "a little after 5:00 AM." Resident ID #8 was observed to be "uncomfortable, restless and kicking [his/her] arms and lifting [his/her] hips off of the bed." Additionally, Staff A, revealed that he was able to obtain pulse oximetry readings (used to monitor arterial oxygen saturation non-invasively) of 79% and 84%. When questioned by the surveyor why oxygen was not administered to the resident per the physician's order when the resident had SpO2 readings of 79% and 84% indicating that s/he was hypoxic, Staff A was unable to answer and acknowledged that the oxygen was not administered as ordered. When questioned what intervention was put in place for the resident related to the abnormal SpO2 readings and the appearance of discomfort, restlessness and the inability to obtain vital signs, Staff A revealed that he raised the resident's head of the bed to 90 degrees. Furthermore, Staff A acknowledged that he was unable to get the tablet working to contact the on-call provider related to the resident's change in condition. When questioned by the surveyor what other interventions were attempted, he revealed that he continued passing medications to the other residents. 2. Record review revealed a physician's order dated 6/11/2025 for Synthroid (a medication prescribed to treat hypothyroidism) 88 micrograms once daily in the morning. Record review of the July 2025 Medication Administration Record revealed that the Synthroid was signed as administered on 7/20/2025 at 5:26 AM.	F0726		

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F0726 SS = D	Continued from page 14 During a surveyor interview on 7/24/2025 at 10:07 AM with Staff A, he revealed that he pre-poured the Synthroid medication for Resident ID #8, signed it off in the electronic medical record prior to administering the medication, and indicated that he was unaware that he was not supposed to sign it off before administering it to the resident. 3. Record review revealed a progress note dated 7/20/2025 at 1:34 AM, which states, "Resident alert w/confusion at baseline. Call light for assistance with transfers and ambulation. Resident verbalizes understanding but has poor follow through. Neuro signs [observable physical indicators that can help diagnose neurological disorders] are stable. AROM [active range of motions refers to unassisted range of movement of a joint] to all extremities. Resident was compliant with diet orders. Resident slept throughout the night with no c/o [complain of] pain or discomfort. During an interview with Staff A on 7/24/2025 at 10:07 AM, he revealed that he has a USB (universal serial bus) drive with a pre-written notes that he copies information from to write his nursing progress notes. Staff A acknowledged that he did not assess the resident's range of motion and neurological status, and that he inaccurately copied that information from his USB drive. During a surveyor interview on 7/24/2025 at 11:30 AM with the Director Nursing Services, she was unable to provide evidence that Staff A was competent in assessing, providing accurate documentation of medication administration and nursing progress notes, despite receiving competencies. Cross reference F 580, F 658, F 684 and F 690	F0726		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(l)(1)(2) §483.60(l) Food safety requirements. The facility must - §483.60(l)(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	F0812	**As a POC for Tag F812:** a) There were no residents identified in this tag. b) Although there were no residents identified in this tag, we recognize the potential risk to residents associated with the issues concerning food sanitation and the cleanliness of the main kitchen noted during the survey and we have since corrected all items identified as problematic.	

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F0812 SS = F	Continued from page 15 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(l)(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, record review and staff interview, it has been determined that the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety relative to the main kitchen and for one of two kitchenettes. Findings are as follows: 1. The Rhode Island Food Code 2022 Edition 4-601.11 states in part, "...nonfood contact surfaces of equipment shall be kept from an accumulation of dust, dirt, food residue and other debris..." During surveyor observations of the main kitchen on 7/22/2025 at 8:50 AM and 7/24/2025 at 10:57 AM revealed the following: -the walls behind the dish machine, stove and worktables were observed to have an accumulation of food spills/splatters -Formica topped food carts were observed to have chips in the corners of the carts -the gaskets of the ice chest had an accumulation of a black substance 2. The Rhode Island Food Code 2022 Edition 4-602.11 states in part, "...equipment of the food contact surfaces...shall be cleaned at any time during the operation when contamination may have occurred..." During a surveyor observation on 7/22/2025 at 8:50 AM of the main kitchen, the delivery chute of the ice machine had a pink substance along the upper rim of the chute.	F0812	c) Our dietary team have been re-educated regarding the importance of compliance with food sanitation regulations. The dietary team are being re-educated regarding the cleanliness required in the kitchen which will also include a revised cleaning schedule, labeling/dating of food items, discarding of food items past the 3 day storing time, the proper temperature of dry storage, the need to ensure carts and other related kitchen equipment is clean and in good repair, and covering the silverware on the meal trays. The ice machine and the gaskets on the ice chest have been cleaned upon surveyor observation of a "pink substance" noted on the ice machine. The Food Service Manager (FSM) is responsible for ensuring all of the education is completed timely and the cleaning schedule is adhered to in the kitchen. d) The FSM/designee is responsible for executing this action plan. Routine audits of the kitchen will be conducted for assurances that these tasks have been completed properly. All audit results will be shared with the QAPI Committee each month for a period of 3 months after which time, the QAPI Committee will evaluate our level of improvement and determine the need/frequency at which to continue or discontinue the formal audits.	

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F0812 SS = F	Continued from page 16 3. The Rhode Island Food Code 2022 Edition 3-302.12 states in part, "...except for containers that can be readily and unmistakably recognized, working containers holding food that are removed from the original packages shall be identified with the common name of the food..." During a surveyor observation on 7/22/2025 at 8:50 AM of the main kitchen, one reach in refrigerator unit revealed the following: -One package of a white colored meat product that was cut up into cubes without a label -1/4-inch pan that contained a red substance was without a label 4. The Rhode Island Food Code 2022 Edition 4-904.13 states in part, "...tableware that is preset shall be protected from contamination by being wrapped or covered..." During surveyor observations of the lunch meal service on 7/22/2025, 7/23/2025 and 7/24/2025 the individual lunch trays were observed on an open cart while being transported on the elevators and along the hallways with preset silverware that were not covered or wrapped. 5. Record review of a document from The United States Department of Agriculture recommends dry food storage temperatures between 50 F (Fahrenheit) and 70 F for quality and for the control of bacterial growth. During a surveyor observation on 7/25/2025 at 10:57 AM, the ambient temperature of the dry storage room read 85 F. 6. Record review of a facility document titled, "Brentwood Nursing Home Refrigerator Dating Guidelines" states in part, "...if a product is opened, then a 3-day expiration must be placed on the product..." During a surveyor observation on 7/22/2025 at 11:30 AM of the first-floor dining room refrigerator, an opened container of a product with a manufacturer's label of "Market Basket Hearty Chicken Noodle soup had a date of 7/16/2025. During a surveyor interview on 7/25/2025 at 11:40 AM with the Director of Food Service he acknowledged the walls, the ice machine and the gaskets on the ice chest needed to be cleaned. Additionally, he acknowledged	F0812		

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F0812 SS = F	Continued from page 17 that the Formica food carts needed to be replaced, the temperature in the dry storage room was too hot, the labels were missing on unidentifiable food items, the chicken soup exceeded the facility's 3-day policy, and that the silverware on meal trays should have been covered.	F0812		
F0921 SS = D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(l) §483.90(l) 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: Based on surveyor observation and staff interview, it has been determined that the facility failed to maintain a sanitary and comfortable environment relative to food trays being left in the hallways on one of two nursing units after meal hours with partially consumed meals. Findings are as follows: During surveyor observations of the first-floor nursing unit, the following was revealed: 7/22/2025 at 11:30 AM, four food trays uncovered from the breakfast meal with partially consumed food 7/22/2025 at 3:45 PM, two food trays uncovered from the lunch meal with partially consumed food 7/23/2025 at 11:30 AM, four trays uncovered from the breakfast meal with partially consumed food 7/24/2025 11:00 AM, three trays uncovered from the breakfast meal with partially consumed food 7/24/2025 at 4:00 PM, four trays uncovered from the lunch meal with partially consumed food During a surveyor interview on 7/25/2025 at 11:40 AM with the Director of Food Service, he acknowledged that the food trucks were left uncovered in the hallway after meal hours and contained partially consumed food on the trays.	F0921	**As a POC for Tag F921:** a) There were no residents identified in this tag. b) Although there were no residents identified in this tag, we recognize the potential risk to residents associated with the issues concerning comfort and the cleanliness of the residents' living environment. c) Our nursing staff and dietary staff have been educated regarding the importance of removing food trays from the units timely after every meal. Dietary staff are responsible for collecting all dirty dishes and meal trays timely and bring those to the main kitchen. The charge nurse, or any manager will be responsible to monitor this after each meal service and will ensure that these dirty trays/dishes get to the kitchen timely (or at least covered and "out of the way" under circumstances when the kitchen may be closed for the night). d) The FSM and the Nursing Management team/designee are responsible for execution of this action plan. We will complete routine observations on all units after each meal to ensure the trays are removed timely. Audit results will be shared with the QAPI Committee monthly for a period of 3 months after which time, the QAPI Committee will evaluate our progress and level of compliance to determine the need/frequency to continue this formal audits.	

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	415061	A. BUILDING B. WING	07/25/2025

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Center for Health Facilities and Regulation on 7/23/2025. The facility was found to be in compliance with 42 CFR §483.73 related to Emergency Preparedness. Capacity: 96 Census: 88	E0000		
K0000	INITIAL COMMENTS The annual Federal Life Safety Code survey was conducted by the State Survey Agency on 7/25/2025. Brentwood Nursing Home 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. No Life Safety Code deficiencies were identified as a result of this survey. The facility is in compliance with all regulations surveyed. Capacity: 96 Census: 88	K0000		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Matthew Maisen	Admin	08/13/25