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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415027	A. BUILDING B. WING	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hill Center for Rehabilitation & Health Care	544 Pleasant Street , Pawtucket, Rhode Island, 02860

(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
F0000	INITIAL COMMENTS A recertification and a complaint investigation surveys, intake reference number 2580692, were conducted at Oak Hill Center for Rehabilitation Center on 8/12/2025 through 8/15/2025 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 109 of 130.	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. Completion date for optimal compliance with POC will be August 28, 2025. **As a POC for Tag F684:** **IMMEDIATE ACTION:** Residents ID #111 and #3 have been seen by a provider and treatment orders obtained for #111 and #3. Staff responsible for missing skin check and treatment orders have been formally educated. **ID OF OTHERS:** We recognize that our residents may be at risk for skin alterations. We have since completed a whole house audit to determine any other possible skin alterations. **SYSTEM CHANGES/EDUCATION:** The nursing management team and Administrator have conducted facility-wide education with nursing staff regarding observation and awareness of skin alterations and the timely notification to providers to obtain treatment orders as needed. Weekly skin meetings will be held to discuss new skin alterations. The nursing management team will conduct weekly skin sweeps to validate accuracy and timeliness of scheduled skin checks.	8/28/25
F0684 SS = G	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: Based on surveyor observation, record review, and staff and resident interviews, it has been determined that the facility failed to provide treatment and care in accordance with professional standards of practice for 2 of 3 residents reviewed relative to skin conditions, Resident ID #s 111 and 3. Findings are as follows: 1) Record review revealed Resident ID #111 was readmitted to the facility in February of 2024 with diagnoses including, but not limited to, diabetes mellitus type 2, morbid obesity, and osteoarthritis.	F0684		

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
Deanna Paul, LNHA	LNHA	8/28/25

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F0684 SS = G	Continued from page 1 Review of a Minimum Data Set (MDS) Assessment dated 6/12/2025 revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. During a surveyor interview on 8/12/2025 at 2:30 PM with Resident ID #111, s/he indicated that s/he had "black stuff" on his/her toes and that s/he had not been seen by the podiatrist in months. The resident further indicated that his/her feet were painful. Record review of a care plan dated 3/27/2024 revealed the resident had the potential for skin alteration related to decreased mobility with interventions including, but not limited to, complete weekly skin checks and to follow the physician's orders for skin care and treatments. Record review revealed the following physician's orders: -3/3/2025- weekly skin evaluation on Fridays during the evening shift, must complete weekly skin monitoring. -6/9/2025- diabetic foot care every evening shift for monitoring Record review of a "Weekly Skin Check" assessment dated 8/1/2025 revealed that the resident's skin was intact and without "foot concerns." Further record review failed to reveal evidence that a "Weekly Skin Check" assessment was completed on 8/8/2025 as ordered. During a surveyor interview on 8/13/2025 at 2:20 PM with Nursing Assistant (NA), Staff F, she stated that she cared for Resident ID #111 that day and did not observe anything wrong with the resident's feet. During a surveyor observation of the resident's feet on 8/13/2025 at 2:22 PM in the presence of Staff F, a buildup of dark colored tissue and matter was observed on the left great toe and on the right great and second toes. During this observation, Staff F indicated that the resident's feet appear to be "normal" and have looked like that for "over a week, at least." During a surveyor interview on 8/13/2025 at 2:22 PM with Licensed Practical Nurse (LPN), Staff G, she indicated that she was unaware of any skin alterations with Resident ID #111's feet. During a surveyor observation of the resident's feet on	F0684	**AUDITS:** The Administrator (NHA) and Director of Nursing (DNS)/designee are responsible for executing this plan. We have devised some audit tools to monitor our progress with this plan; the audit tools will include evidence of monitoring skin checks and reporting findings to the provider if warranted. The plan and audits are to be reviewed by the QAPI Committee monthly for no less than 3 months after which time, the Committee will determine progress and the frequency necessary to continue the audits. The plan will be revised as needed to achieve compliance.	8/28/25

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F0684 SS = G	Continued from page 2 8/13/2025 at 2:23 PM, in the presence of Staff G, she acknowledged the buildup of dark colored tissue and matter. Staff G indicated that she had not been made aware of the skin alterations of the resident's feet until it was brought to her attention by the surveyor. Record review of a podiatry exam note dated 3/31/2025 revealed the resident's skin color was normal with no ulcers, and house lotion was recommended twice daily to both feet to boost skin integrity. Record review failed to reveal evidence that house lotion was being applied to the resident's feet twice daily. During a surveyor interview on 8/13/2025 at 2:27 PM with the Assistant Director of Nursing Services (ADNS), she indicated that she follows the wounds in the facility and that she was not aware of any areas of concern to Resident ID #111's feet. Additionally, she assessed the resident's feet after the surveyor brought the issue to her attention and she acknowledged the buildup of tissue and matter with dark discoloration. Record review revealed the following physician's orders were obtained after the above-mentioned skin alterations were brought to the facility's attention by the surveyor: -Left first toe- cleanse with normal saline, pat dry, apply bacitracin to wound bed followed by a bordered gauze every evening shift for skin alteration care -Right first toe- cleanse with normal saline, pat dry, apply bacitracin to wound bed followed by a bordered gauze every evening shift for skin alteration care -Soak feet at bedtime with warm water, pat dry followed by lotion to feet every evening shift for foot care. Record review revealed the resident was seen by the podiatrist on 8/14/2025, after the alterations of the resident's feet were brought to the facility's attention. Further review revealed ingrown toenails with pyogenic granuloma (a skin condition characterized by a buildup of immune cells that form a localized raised area) and pain were noted on both of the resident's left and right great toes. Further review revealed red, beefy granulation tissue (new tissue that forms on the surface of wounds during the healing process) was noted to the nail fold. Additionally, silver nitrate (a topical chemical compound that is used to cauterize and remove excess granulation tissue) was applied to both nail folds to cauterize the	F0684		

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F0684 SS = G	Continued from page 3 granuloma. During a surveyor interview and observation of the resident's feet on 8/15/2025 at 1:30 PM with the ADNS, she stated that the buildup on the resident's feet would not have occurred if diabetic foot care had been completed daily as ordered. She further noted that the buildup on the resident's right second toe was able to be removed. Additionally, she reported that after the resident received treatment from the podiatrist, new open areas were identified. The open areas were measured as follows: left great toe, 5 millimeters (mm) by 2 mm; right great toe, 13 mm by 5 mm. During a surveyor interview on 8/15/2025 at 1:36 PM with the Director of Nursing Services (DNS), she was unable to provide evidence that the weekly skin check assessment for 8/8/2025 had been completed as ordered. She also acknowledged that Resident ID #111 was found to have new skin alterations on his/her feet after it was brought to the facility's attention by the surveyor, which required physician intervention and resulted in open areas. 2. Record review revealed Resident ID #3 was admitted to the facility in July of 2025 with diagnoses including, but not limited to, diabetes mellitus type 2, chronic obstructive pulmonary disease (COPD), and morbid obesity. Review of the MDS Assessment dated 7/30/2025 revealed a BIMS score of 14 out of 15, indicating the resident's cognition was intact. Record review of a "Weekly Skin Check" assessment dated 8/14/2025 indicated that the resident's skin was intact with no concerns. During a surveyor interview on 8/15/2025 at 10:45 AM with Resident ID #3, s/he indicated that s/he had a wound on his/her abdomen. The resident further indicated that s/he had picked at an old scar and sometimes they put a bandage on it. During a surveyor observation at the time of the above interview, a superficial wound was observed to the resident's upper left area of his/her abdomen measuring approximately 3 centimeters (cm) by 2 cm. During a surveyor interview on 8/15/2025 at 10:53 AM with LPN, Staff G, she indicated that she was made aware of the open area on the resident's abdomen yesterday, 8/14/2025 on the 7:00 AM to 3:00 PM shift; however, she did not notify the provider for an	F0684		

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F0684 SS = G	Continued from page 4 intervention or complete the skin assessment. During a surveyor interview on 8/15/2025 at 10:57 AM with the DNS, she indicated that she would expect that the provider would be notified of a new open area and that the wound would be reflected on the skin assessment. F0689 Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on surveyor observation, record review, and resident and staff interviews, it has been determined that the facility failed to ensure that a resident received adequate supervision for 1 of 1 resident reviewed who was assessed to be at risk for elopement and failed to ensure that a resident is provided assistive devices to prevent accidents relative to smoking for 1 of 1 resident reviewed, Resident ID #31. Findings are as follows: Record review of a facility policy titled "Elopement Prevention" dated 10/2022, states in part, "...The facility maintains a process to assess all residents for risk for elopement, implement prevention strategies for those identified as an elopement risk, Elopement is the ability of a resident who is not capable of protecting himself or herself from harm to successfully leave the facility unsupervised and unnoticed and who may enter harm's way...Interventions that may be used for residents identified at risk for elopement includes...frequent monitoring of the resident's whereabouts to assure he or she remains in the facility...utilize a "sign out" book on units for all activities off unit...disciplines working with residents who are at risk for elopement will take into consideration to alert other staff member when resident is left unattended..."	F0684 F0689	**As a POC for Tag F689:** **IMMEDIATE ACTION:** Resident ID #31, no harm came to this individual, a new elopement assessment was completed showing no change in elopement risk. Resident also had a complete skin check resulting in no findings. The wandergard was assessed to be working appropriately. The contractor responsible, (and his team) for escorting Resident ID #31 has been educated to not escort residents from their unit/floor. **ID OF OTHERS:** We recognize our resident population is at risk for elopement and some residents require assistive devices while smoking to remain free of accidents. A full house audit was completed to determine elopement risk for all residents and residents requiring an assistive device when smoking. **SYSTEM CHANGES/EDUCATION:** The nursing management team has conducted facility-wide education regarding observation and awareness of residents at risk for elopement and the timely notification to IDT with new at risk residents. Education has been provided to staff to not provide visitors, contractors, or vendors with door codes. staff are to escort/open doors for vendors. contractors, and visitors. Elopement binders are updated with all residents who are determined to be at risk with the residents picture and identifying features. Education has been provided to the Activity staff regarding securing all smoking items, i.e. lighters at the end of each smoking session. Activities has adjusted their inventory of smoking devices to include only one lighter at each smoking session to ensure all items are accounted for at the end of each session. All residents that wish to smoke have been provided with a new copy of the smoking policy to which they signed in acknowledgement. Weekly meetings will be held with IDT to identify at risk individuals.	8/28/25

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F0689 SS = D	Continued from page 5 Record review revealed the resident was admitted to the facility in June of 2023 with diagnoses including, but not limited to, schizophrenia (a serious mental health condition that affects how people think, feel and behave), anxiety, and tobacco use. Review of the Minimum Data Set Assessment dated 6/3/2025 revealed a Brief Interview for Mental Status score of 0 out of 15, indicating s/he has severely impaired cognition. 1a. Record review of an elopement evaluation dated 9/6/2024 revealed the resident scored a two; a score value of one or higher indicates the resident is at risk for elopement. Record review revealed a physician's order dated 6/23/2025 to check the resident's wander guard placement (a device used to monitor and prevent individuals from wandering, particularly in environments where safety is a concern. The device is typically worn as a bracelet or ankle band by the individual, and it is equipped with sensors that trigger alarms or alerts if the person moves beyond a designated area. This helps to ensure that people do not accidentally leave a secure environment or wander into potentially dangerous situations) to right wrist, every shift for safety. Review of a care plan, last updated on 4/4/2024, indicates that the resident is at high risk for elopement due to a pattern of wandering behavior. Interventions to address this risk include, but are not limited to, ensuring the resident is always supervised when outside and the use of a wander guard placed on their right wrist. During a surveyor observation on 8/13/2025 at 8:36 AM, the resident was seen entering the 2nd floor elevator with Staff I, a contracted worker performing maintenance on the building. Immediately following the above observation, the resident was observed by the surveyor on the ground floor level outside of the facility in the rear patio area unsupervised by staff. During this observation another resident alerted Nursing Assistant (NA), Staff F, that Resident ID #31 was outside unsupervised. During a surveyor interview on 8/13/2025 at 11:16 AM with Staff F, she acknowledged that another resident brought to her attention that the resident was outside unsupervised and s/he should not have been.	F0689	**AUDITS:** The Administrator (NHA) and Director of Nursing (DNS)/designee are responsible for executing this plan. We have devised some audit tools to monitor our progress with this plan; the audit tools will include evidence of monitoring residents for an increased risk of elopement. The plan and audits are to be reviewed by the QAPI Committee monthly for no less than 3 months after which time, the Committee will determine progress and the frequency necessary to continue the audits. The plan will be revised as needed to achieve compliance. 8/28/25 8/28/25	

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F0689 SS = D	Continued from page 6 During a surveyor interview on 8/13/2025 at 8:54 AM with Licensed Practical Nurse (LPN), Staff J, she acknowledged that the resident was found outside unsupervised and should not have been. During a surveyor interview with Staff I, he indicated that he escorted the resident to the first floor so s/he could smoke. He further indicated that the resident entered the rear patio area after he entered the code into the wander guard keypad system which disabled the alarm to the external door, to allow the resident outside. Additionally, he indicated he was not aware that the resident required supervision while outside of the facility. 1b. Review of a facility policy titled "Smoking and Safety Evaluation" Last revised 10/2022 states in part, "An individualized plan of care should be developed for the resident to ensure their smoking safety based on the outcome of their smoking assessment...Safety equipment such as but not limited to smoking apron will be provided as needed based on the outcome of the residents smoking assessment...residents are not permitted to hold their smoking materials...resident smoking materials will be stored by the facility in a locked area..." Review of a "Smoking and Safety Evaluation" dated 8/5/2025 revealed that the resident is a current smoker and requires the use of a smoking apron when s/he smokes tobacco products. Review of a care plan last revised on 7/19/2025 revealed that the resident is a smoker with interventions including, but not limited to, smoking materials to be held by staff, cigarettes and or lighting material to be given by staff at designated times. During a surveyor observation on 8/13/2025 at 8:40 AM the resident was observed sitting outside the facility on the patio with a cigarette and lighter, s/he lit the cigarette, and was observed to be smoking not utilizing a smoking apron per his/her smoking assessment. During surveyor interviews on 8/13/2025 at 8:54 AM and 10:58 AM with LPN, Staff J, she acknowledged that the resident's smoking assessment revealed that the resident should be utilizing a smoking apron and acknowledged the resident had a lighter in his/her procession and should not have. During a surveyor interview on 8/13/2025 at 11:18 AM	F0689		

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F0689 SS = D	Continued from page 7 with the Administrator, she acknowledged that the facility's contracted workers should not have escorted the resident off the unit. Additionally, she indicated that it would be her expectation that the resident would not have been outside unattended, as s/he is an elopement risk. Further, she revealed the resident should not have any smoking implements and requires a smoking apron while smoking.	F0689	**As a POC for Tag F726:** **IMMEDIATE ACTION:** Staff ID #s K, L, and M have been educated and competencies have been completed regarding PPE requirements. **ID OF OTHERS:** We recognize that residents may be at risk for contracting infections with improper PPE use and improper handwashing. We have since completed whole house education pertaining to handwashing and PPE requirements with return demonstration. **SYSTEM CHANGES/EDUCATION:** The nursing management team and Administrator have conducted facility-wide education regarding observation and awareness of PPE requirements and handwashing. Weekly random audits will be completed to identify staff continue to utilize the appropriate PPE. **AUDITS:** The Infection Preventionist and Director of Nursing (DNS)/designee are responsible for executing this plan. We have devised some audit tools to monitor our progress with this plan; the audit tools will include monitoring PPE and handwashing compliance. The plan and audits are to be reviewed by the QAPI Committee monthly for no less than 3 months after which time, the Committee will determine progress and the frequency necessary to continue the audits. The plan will be revised as needed to achieve compliance.	8/28/25
F0726 SS = E	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 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 surveyor observation, and staff and resident interviews, it has been determined that the facility	F0726	8/28/25	

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F0726 SS = E	Continued from page 8 failed to have sufficient nursing staff with the appropriate competencies and skill sets to help prevent the transmission of communicable diseases and infections for 3 of 4 nursing staff, Staff IDs K, L, and M, interviewed regarding contact precautions (infection control measures which require specific personal protective equipment (PPE)); Resident ID #2 requires the use of infection control measures of donning a gown and gloves when entering the resident's room. Findings are as follows: Review of a facility policy titled, "Isolation Precautions" states in part, "...Implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment...Place 'isolation' sign at door of resident's room..." Record review revealed Resident ID #2 was readmitted to the facility with a diagnosis including, but not limited to, ESBL (a multidrug resistant organism) infection in the urine. Record review revealed a physician's order dated 8/7/2025 for contact precautions every shift related to ESBL in the urine. During a surveyor observation on 8/14/2025 at approximately 12:00 PM signage on the resident's door stated, "Contact Precautions Everyone Must" Clean their hands including before entering and when leaving the room. Providers and Staff Must Also: Put on glove before room entry...Put on gown before room entry..." During a surveyor observation on 8/14/2025 at 12:10 PM, Nursing Assistant (NA) Staff K, entered Resident ID #2's room without performing hand hygiene and without putting on a gown or gloves. She assisted the resident with his/her glasses then exited the room without performing hand hygiene. She then entered another resident's room across the hall for a short time then re-entered Resident ID #2's room, without performing hand hygiene and without putting on a gown or gloves. While in the room, Staff K went over to Resident ID #2 and was behind the privacy curtain. During a surveyor interview on 8/14/2025 at approximately 12:15 PM with Staff K, she indicated that she was unaware Resident ID #2 was on contact precautions. She further indicated that she did not see	F0726		

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F0726 SS = E	Continued from page 9 the sign indicating the need for contact precautions. Additionally, she acknowledged that the signage on Resident ID #2's door indicates to perform hand hygiene before entering and exiting the room, and to put on a gown and gloves before entering the room. Furthermore, she indicated that she thought contact precautions only required putting on a gown and gloves when touching the resident. During a surveyor interview on 8/14/2025 at 12:01 PM with Certified Medication Technician, Staff L, she indicated that you only need to wear a gown and gloves when touching a resident on contact precautions. During a surveyor interview on 8/14/2025 at 12:16 PM with Licensed Practical Nurse (LPN), Staff M, she was unable to answer any questions relative to contact precautions. During a surveyor interview on 8/14/2025 at 12:30 PM with the Assistant Director of Nursing Services and Infection Preventionist, Staff H confirmed that Staff K, L, and M had completed competencies related to infection control practices. However, she was unable provide evidence these staff members were able to demonstrate knowledge of the appropriate competencies and skills for caring for a resident on contact precautions. Cross Reference F 880	F0726		8/28/25
F0825 SS = G	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(f), obtain the required services from an outside resource that is a	F0825	**As a POC for Tag F825:** **IMMEDIATE ACTION:** Residents ID #s 8 and 42 have been evaluated by physical therapy. **ID OF OTHERS:** We recognize that residents may be at risk for a physical decline in function. We have since reviewed each resident in comparison with their last MDS to determine if a physical decline has occurred. **SYSTEM CHANGES/EDUCATION:** House wide education regarding residents requiring more assistance with ADL's has been conducted, including submitting a referral for therapy for screening/evaluation. Education will be conducted upon hire, annually, and as needed.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415027	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0825 SS = G	Continued from page 10 provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff and resident interview, it has been determined that the facility failed to provide specialized rehabilitation services such as physical therapy and occupational therapy, that are required per the resident's comprehensive plan of care for 2 of 2 residents reviewed with a decline in activities of daily living (ADL) functional abilities, Resident ID #s 8 and 42. Findings are as follows: 1. Record review revealed Resident ID #8 was readmitted to the facility in October of 2024 with diagnoses including, but not limited to, hemiplegia (paralysis) and hemiparesis (weakness) of the left non-dominant side following a stroke and left foot drop (the inability to lift the front part of your foot causing it to drag). During a surveyor interview with the resident on 8/13/2025 at 8:49 AM, the resident reported that they had not received therapy in several months and expressed that they are unable to do as much as they were previously able to. Record review of a Quarterly Minimum Data Set (MDS) Assessment dated 4/10/2025, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating s/he is cognitively intact. Further review revealed the resident was coded as a "6" for functional abilities, indicating s/he does not require assistance for eating, oral and personal hygiene, toileting hygiene, shower/bathing, dressing, and putting on footwear. Record review of a subsequent Quarterly MDS Assessment dated 7/10/2025 revealed the resident is now coded as a "4" for functional abilities indicating that s/he requires verbal cues and/or touching/steadying and/or contact guard assistance for eating, oral and personal hygiene, toileting hygiene, shower/bathing, dressing, and putting on footwear. Record review of the care plan revised on 8/4/2025, indicates the resident requires assistance with ADL's related to weakness and stroke with a goal that the resident's ADL status will improve through the next	F0825	**AUDITS:** The MDS Nurse and Director of Nursing (DNS)/designee are responsible for executing this plan. We have devised some audit tools to monitor our progress with this plan; the audit tools will include monitoring residents' functional levels and identifying changes. The plan and audits are to be reviewed by the QAPI Committee monthly for no less than 3 months after which time, the Committee will determine progress and the frequency necessary to continue the audits. The plan will be revised as needed to achieve compliance	

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F0825 SS = G	Continued from page 11 review date. Further review revealed interventions, including, but not limited to, providing one staff member for assistance with personal care, personal hygiene and mouth care and to monitor for changes in status. Record review failed to reveal evidence that a screening for therapy services was completed following an identified decrease in ADL functioning. During surveyor interviews on 8/15/2025 at 9:55 AM and 12:25 PM with the Director of Rehabilitation, Staff A, she revealed that the resident was last discharged from Physical Therapy (PT) and Occupational Therapy (OT) services as of 5/20/2025 and has not received therapy services since. Additionally, she indicated that residents are screened for the need for therapy services during the Quarterly and Annual MDS assessment periods and when nursing notices a decline in residents' functional abilities. Staff A was unable to provide evidence that a therapy screen or referral for therapy was completed after a decline was identified in the Quarterly MDS Assessment dated 7/10/2025. 2. Record review revealed Resident ID #42 was admitted to the facility in October of 2024 with diagnoses including, but not limited to, urinary retention and coronary artery disease. During a surveyor interview with the resident on 8/13/2025 at 8:50 AM s/he revealed that s/he hasn't had therapy in many months and has not walked. The resident further revealed that s/he wants to walk daily. Record review of an Annual MDS Assessment dated 8/7/2025, revealed a BIMS score of 14 out of 15, indicating s/he is cognitively intact. Further review of the MDS failed to reveal evidence that the resident ambulated 10, 50, or 150 feet during the assessment period. Record review of the PT Discharge Summary document dated 6/27/2025 revealed the following short and long-term goals: -Increase the ability to stand supported for 15 minutes to initiate gait activities -Once standing, the resident will improve the ability to safely ambulate 50 feet and make two turns with partial/moderate assistance while using a two-wheeled walker -Once standing, the resident will improve the ability	F0825		

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F0825 SS = G	Continued from page 12 to safely ambulate 150 feet in a corridor with partial/moderate assistance while using a two-wheeled walker Further review of the discharge summary document revealed the resident met his/her short and long-term goals and has made consistent progress with skilled interventions. The document indicates that the resident and staff were in-serviced relative to ambulation with contact guard assist and a two-wheeled walker. Additionally, the document indicates the resident's prognosis to maintain his/her current level of functioning is excellent with consistent staff support. Record review of an undated in-service document completed for the resident by the Physical Therapist revealed that a skills demonstration was provided to staff to ambulate the resident with contact guard assistance with a two-wheeled walker, up to 150 feet. During a surveyor interview on 8/13/2025 at approximately 9:00 AM with Licensed Practical Nurse, Staff D, she indicated she was unable to recall the last time the resident ambulated with staff. She further revealed that the last time the resident was assisted with ambulating, s/he was unable to ambulate due to being unsteady and shaking. Additionally, Staff D confirmed that the resident has not had physical therapy since 6/27/2025. During a surveyor interview on 8/15/2025 at 1:10 PM with NA, Staff E, she revealed that the resident always asks to walk, but she is unsure if the resident is supposed to walk. During a surveyor interview on 8/15/2025 at 9:55 AM with Director of Rehabilitation, Staff A, she acknowledged that the resident has not received therapy since s/he was discharged on 6/27/2025. She further revealed that on 8/14/2025 the Physical Therapist completed an evaluation for PT services, after the resident's concerns were brought to nursing by the surveyor. Additionally, she acknowledged that the PT evaluation indicated that the resident had a decline in function since s/he was discharged from therapy services on 6/27/2025. Record review of the PT Evaluation and Plan of Treatment dated 8/14/2025, indicates that the resident presented with significant decrease in muscle strength and balance, decreased safety awareness, and a decrease in activity intolerance with prolonged activities. During a surveyor interview on 8/15/2025 at 1:16 PM	F0825		

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F0825 SS = G	Continued from page 13 with the Director of Nursing Services, she revealed that if the MDS indicates a decline in functional abilities, then she would expect that a request for a therapy screen would be completed. Additionally, the DNS was unable to provide evidence Resident ID#'s 8 and 42 were screened or evaluated by physical therapy after a decrease in ADL function.	F0825		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F0880	**As a POC for Tag F880:** **IMMEDIATE ACTION:** Resident ID #2 had no negative outcome. Staff have been educated regarding appropriate PPE use. **ID OF OTHERS:** We recognize that residents may be at risk for contracting infections with improper PPE use and improper handwashing. We have since completed whole house education pertaining to handwashing and PPE requirements with return demonstration. **SYSTEM CHANGES/EDUCATION:** The nursing management team and Administrator have conducted facility-wide education regarding observation and awareness of PPE and handwashing requirements. Weekly random audits will be completed to identify staff observations related to PPE use. **AUDITS:** The Infection Preventionist and Director of Nursing (DNS)/designee are responsible for executing this plan. We have devised some audit tools to monitor our progress with this plan; the audit tools will include PPE and handwashing observations. The plan and audits are to be reviewed by the QAPI Committee monthly for no less than 3 months after which time, the Committee will determine progress and the frequency necessary to continue the audits. The plan will be revised as needed to achieve compliance.	8/28/25

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F0880 SS = D	Continued from page 14 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections, relative to staff wearing the appropriate personal protective equipment (PPE) for 1 of 1 resident reviewed with an order for contact precautions (infection control measures which require donning a gown and gloves upon entering the resident's room) for Extended-spectrum beta-lactamase producing bacteria (ESBL- an antibiotic resistant bacteria), Resident ID #2. Findings are as follows: Review of a facility policy titled, "Isolation Precautions" states in part, "...Implement Contact	F0880		

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F0880 SS = D	Continued from page 15 Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment...Place 'isolation' sign at door of resident's room..." Record review revealed Resident ID #2 was readmitted to the facility in June of 2025 with a diagnosis including, but not limited to, ESBL in the urine. Record review revealed a physician's order dated 8/7/2025 for contact precautions every shift related to ESBL in the urine. During a surveyor observation on 8/14/2025 at approximately 12:00 PM revealed signage on Resident ID #2's door stating, "Contact Precautions Everyone Must" Clean their hands including before entering and when leaving the room. Providers and Staff Must Also: Put on glove before room entry...Put on gown before room entry..." During a surveyor observation on 8/14/2025 at 12:10 PM, Nursing Assistant (NA), Staff K, entered Resident ID #2's room without performing hand hygiene and without putting on a gown or gloves. She assisted the resident with his/her glasses then exited the room without performing hand hygiene. She then entered another resident's room across the hall for a short time then reentered Resident ID #2's room again, without performing hand hygiene and without putting on a gown or gloves. While in the room, Staff K went over to Resident ID #2 and was behind the privacy curtain. During a surveyor interview in 8/14/2025 at approximately 12:15 PM with Staff K, she indicated that she was unaware that Resident ID #2 had an order for contact precautions. She further indicated that she did not see the sign on the door indicating contact precautions were in place. Additionally, she acknowledged that the signage on Resident ID #2's door indicates to perform hand hygiene before entering and exiting, and to put on a gown and gloves before entering the room. Furthermore, she indicated that she thought contact precautions only required putting on a gown and gloves when touching the resident. During a surveyor interview on 8/14/2025 at 12:18 PM with Licensed Practical Nurse (LPN), Staff P, she indicated that Resident ID #2 was actively being treated for ESBL and had an order for contact precautions. Additionally, she indicated that she would expect staff to put on a gown and gloves upon entering the resident's room.	F0880		

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F0880 SS = D	Continued from page 16 During a surveyor interview on 8/14/2025 at 12:30 PM with the Assistant Director of Nursing Services and the Infection Preventionist, Staff H, she acknowledged that Resident ID #2 was actively being treated for ESBL in his/her urine and had a physician's order for contact precautions. Additionally, she indicated that she would expect staff to perform hand hygiene before and after entering a resident's room and put on a gown and gloves upon entering a resident's room. Cross reference F-726	F0880		

Rhode Island State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: LTC00840	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

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M0715	1.16.6.C Nursing Service & Minimum Staffing CFR(s): RESIDENT CARE SERVICES 1.16.6.C. Each facility shall have a registered nurse on the premises twenty-four (24) hours a day. In addition, the necessary nursing service personnel (licensed and nonlicensed) shall be in sufficient numbers on a twenty-four (24) hour basis, to assess the needs of resident, to develop and implement resident care plans, to provide direct resident care services, and to perform other related activities to maintain the health, safety and welfare of residents. 1. There shall be a master plan of the staffing pattern for providing twentyfour (24) hour direct care nursing service; for the distribution of direct care nursing personnel for each floor and/or residential area; for the replacement of direct care nursing personnel; and for forecasting future needs. The staffing pattern shall include provisions for registered nurses, licensed practical nurses, nursing assistants, medication technicians, licensed physical therapists, licensed occupational therapists, licensed speech-language pathologists, physical therapist assistants and other personnel as required. 2. Each nursing facility shall include direct caregivers, including at least one (1) nursing assistant, in the process to create the master plan of the staffing pattern and the federally mandated facility assessment. If the nursing assistants in the nursing facility are represented under a collective bargaining agreement, the bargaining unit shall coordinate voting to allow the nursing assistants to select their representative. 3. The number and type of nursing personnel shall be based on resident care needs and classifications as determined for each residential area. Each nursing facility shall be responsible to have sufficient qualified staff to meet the needs of the residents.	M0715	As a POC for Tag M715: **IMMEDIATE ACTION:** The nursing schedule has been audited to determine the hiring needs of the facility. **ID OF OTHERS:** We recognize our residents have the risk of insufficient care if appropriate staffing is not met. **SYSTEM CHANGES/EDUCATION:** The DNS and Staffing coordinator have been educated on the staffing requirements regarding 24-hour RN coverage. **AUDITS:** The DNS and Staffing Coordinator will make every effort to coordinate with local schools and job fairs to recruit Registered Nurses. Advertisements have been placed through Apploi. Weekly schedule reviews will be made with the NHA. DNS. and Staffing Coordinator. The plan and audits are to be reviewed by the QAPI Committee monthly for no less than 3 months after which time, the Committee will determine progress and the frequency necessary to continue the audits. The plan will be revised as needed to achieve compliance.	8/28/25

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deanna Paul	LNHA	8/28/25

Rhode Island State Department of Health

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M0715	Continued from page 1 4. At least two (2) individuals who are certified in Basic Life Support must be available twenty-four (24) hours a day within the nursing facility. One (1) of these individuals must be a licensed nurse. 5. Commencing on January 1, 2022, nursing facilities shall provide a quarterly minimum average specified in R.I. Gen. Laws § 23-17.5-32(c)(i). 6. Commencing on January 1, 2023, nursing facilities shall provide a quarterly minimum average specified in R.I. Gen. Laws § 23-17.5-32(c)(ii). a. In accordance with R.I. Gen. Laws § 23-17.5-32(d), Director of Nursing hours and nursing staff hours spent on administrative duties or non-direct caregiving tasks are excluded and may not be counted toward compliance with the minimum staffing hours requirement in §§ 1.16.6(C)(5) and (6) of this Part. b. Nursing facilities that are certified by the Federal Centers for Medicare and Medicaid Services (CMS) shall access and report data using CMS' payroll-based journal database in accordance with R.I. Gen. Laws § 23-17.5-33(a)(2). c. Nursing facilities that are not certified by CMS (State licensure only) shall report data to the licensing agency in a form and manner as prescribed by the Director. 7. In accordance with R.I. Gen. Laws § 23-17.5-32(e), the requirements of §§ 16.6.(C)(5) and (6) of this Part are minimum standards only. Nursing facilities shall employ and schedule additional staff as needed to ensure quality resident care based on the needs of individual residents and to ensure compliance with all relevant State and Federal staffing requirements. 8. Compliance and enforcement for § 1.16.6 of this Part shall be done in accordance with R.I. Gen. Laws § 23-17.5-33. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to ensure that a	M0715		

Rhode Island State Department of Health

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M0715	Continued from page 2 Registered Nurse (RN) was on the premises twenty-four (24) hours a day for 16 out of the 28 days reviewed. Findings are as follows: Review of the nursing schedules provided by the Administrator dated Sunday, 7/20/2025 through Saturday 8/16/2025 failed to reveal evidence of twenty-four-hour RN facility coverage on the following dates: -7/20/2025 11:00 PM-7:00 PM -7/24/2025 3:00 PM-11:00 PM -7/25/2025 3:00 PM-11:00 PM -7/26/2025 11:00 PM-7:00 AM -7/27/2025 7:00 AM-3:00 PM, 3:00 PM-11:00 PM, or 11:00 PM -7:00 AM -7/31/2025 3:00 PM-11:00 PM and 11:00 PM-7:00 AM -8/1/2025 3:00 PM-11:00 PM and 11:00 PM-7:00 AM -8/7/2025 3:00 PM-11:00 PM and 11:00 PM-7:00 AM -8/8/2025 7:00 AM-3:00 PM, 3:00 PM-11:00 PM, or 11: 00 PM-7:00 AM During a surveyor interview on 8/14/2025 at 10:15 AM with the Administrator, she acknowledged that the facility failed to have RN coverage 24 hours a day on the above-mentioned dates as required.	M0715		

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(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
K0000	INITIAL COMMENTS The annual Federal Life Safety Code survey was conducted by the State Survey Agency. Oak Hill Center of Rhode Island 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. Capacity: 129 Census: 109	K0000	**As a POC for Tag K324:** **IMMEDIATE ACTION:** There were no residents identified in this tag. **ID OF OTHERS:** Although there were no residents identified in this tag, we recognize the potential risk to residents and others associated with the lack of kitchen suppression maintenance. We have addressed the issue. **SYSTEM CHANGES/EDUCATION:** The NHA has signed a contact with Everon to maintain our kitchen fire suppression system. This was completed in May 2025 and is scheduled to be completed in November 2025 and every 6 months thereafter. The Director of Maintenance is responsible for ensuring this is completed properly on a routine basis.	8/28/25
K0324 SS = F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on surveyor observations, record review, and	K0324		

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
Deanna Paul, LNHA	LNHA	8/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415027	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

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K0324 SS = F	Continued from page 1 staff interview, it has been determined that the facility failed to maintain the kitchen hood suppression system in accordance with National Fire Protection Association (NFPA) 101 Life Safety Code 2012 Edition section 9.2.3 and NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 2011 Edition section 11.2 and section 11.6. This deficient practice has the potential to impact 109 of 109 residents, as well as an indeterminable number of staff and visitors. Findings are as follows: NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 2011 Edition section 11.2 states in part, "...11.2.1* Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person (s) acceptable to the authority having jurisdiction at least every 6 months." Record review of NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 2011 Edition section 11.2 states in part "...11.2.1* Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person (s) acceptable to the authority having jurisdiction at least every 6 months." During a surveyor observation of the kitchen fire suppression system during the life safety tour, on 8/14/2025, the kitchen fire suppression system service ticket revealed it was last serviced in May of 2025, indicating the previous required semiannual service would have been due in November of 2024. Record review of the building's kitchen fire suppression system service reports on 8/13/2025 revealed the systems last semiannual service date was May of 2025. The facility was unable to provide evidence that the November 2024 service was completed, as required. During a surveyor interview with the Administrator on 8/14/2025 at approximately 2:45 PM, she acknowledged	K0324	**AUDITS:** The Director of Maintenance will report to the QAPI Committee each month to make them aware of inspection dates and compliance. The QAPI Committee will review this issue for a period of no less than three months after which time, they will re-evaluate the frequency of review of this Life Safety element.	8/28/25

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415027	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

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K0324 SS = F	Continued from page 2 that the kitchen fire suppression system was last serviced in May of 2025 and could not provide evidence that the November 2024 service was done, as required.	K0324	**As a POC for Tag 345:** **IMMEDIATE ACTION:** There were no residents identified in this tag. **ID OF OTHERS:** Although there were no residents identified in this tag, we recognize the potential risk to residents and others associated with the lack of compliance with the smoke detectors being inspected and tested every quarter. We have corrected this issue. **SYSTEM CHANGES/EDUCATION:** The NHA has entered into a new contract with [redacted] for our fire inspection needs. They were in on 8/13/25 to complete the quarterly testing and on 8/25/25 they are scheduled to return and install a new fire panel and perform testing on all of the fire protection equipment including, but not limited to, smoke detectors, fire alarms, and sprinkler systems. Next scheduled appointment is 10/2/25.	8/28/25
K0345 SS = F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to ensure that the fire alarm system was maintained in accordance with National Fire Protection Association (NFPA) 101 Life Safety Code, 2012 Edition, and NFPA 72 National Fire Alarm and Signaling Code, 2010 Edition. This deficient practice has the potential to impact 109 of 109 residents, as well as an indeterminable number of staff and visitors. Findings are as follows: Review of the NFPA 72 National Fire Alarm and Signaling Code, 2010 Edition, states in part, "...9.6 Fire Detection, Alarm, and Communications Systems. 9.6.1* General. 9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use..." Record review of NFPA 72 National Fire Alarm and Signaling Code 2010 Edition states in part, "...14.4 Testing.	K0345		

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K0345 SS = F	Continued from page 3 14.4.5* Testing Frequency. Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction..." Record review of the last four quarterly (every three months) fire alarm system maintenance reports, failed to reveal evidence that the facility completed the quarterly maintenance testing between 9/16/2024 and 8/13/2025, as required. During a surveyor interview on 8/14/2025 at approximately 2:40 PM, with the Maintenance Director and the Administrator, they could not provide evidence that the fire alarm system received quarterly testing maintenance, as required.	K0345	**AUDITS:** The Director of Maintenance will report to the QAPI Committee each month to make them aware of the status of the required fire protection equipment inspections that are needed and/or in progress. The QAPI Committee will review this issue for a period of no less than three months after which time, they will re-evaluate the frequency of review of this Life Safety element.	8/28/25
K0353 SS = F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on surveyor observations, record review, and staff interview, it has been determined that the facility failed to ensure that the automatic sprinkler system was being maintained in accordance with National Fire Protection Association (NFPA) 101 Life Safety Code 2012 Edition sections 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K0353	**As a POC for Tag K353:** **IMMEDIATE ACTION:** There were no residents identified in this tag. **ID OF OTHERS:** Although there were no residents identified in this tag, we recognize the potential risk to residents and others associated with the lack of evidence confirming sprinkler system inspection and testing. We have corrected this issue.	

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K0353 SS = F	Continued from page 4 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 2011 edition. This deficient practice has the potential to impact 109 of 109 residents, as well as an indeterminable number of staff and visitors. Findings are as follows: Record review of NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 2011 Edition states in part, "...4.5 Testing. 4.5.1 All components and systems shall be tested to verify that they function as intended. 4.5.2 The frequency of tests shall be in accordance with this Standard. 4.7* Maintenance. Maintenance shall be performed to keep the system equipment operable or to make repairs..." NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 2011 edition states in part, "...5.1.1.2 Table 5.1.1.2 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. 5.3.2* Gauges. 5.3.2.1 Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. 5.3.3 Waterflow Alarm Devices. 5.3.3.1 Mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly..." Record review of the sprinkler system quarterly reports (every three months) on 8/13/2025, failed to reveal that maintenance of the sprinkler system was completed quarterly, as required. During a surveyor interview on 8/14/2025 at approximately 2:45 PM, with the Maintenance Director and the facility Administrator, they could not provide evidence that the sprinkler system received quarterly maintenance, as required.	K0353	**SYSTEM CHANGES/EDUCATION:** We have since signed a new contract with [redacted] for our fire protection needs. An inspection date of 8/13/25 has been completed and they performed testing on all of our fire protection equipment including, but not limited to, smoke detectors, fire alarms and sprinkler systems. Next scheduled appointment is 10/2/25. **AUDITS:** The Director of Maintenance will report to the QAPI Committee each month to make them aware of the status of the required fire protection equipment inspections that are needed and/or in progress. The QAPI Committee will review this issue for a period of no less than three months after which time, they will re-evaluate the frequency of review of this Life Safety element.	8/28/25

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K0353 ~~K0918~~ SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to ensure that the Emergency Power Supply System (EPSS) generator was maintained in accordance with National Fire Protection Association (NFPA) 99 Health Care Facilities Code 2012 Edition, NFPA 101 Life Safety Code 2012 Edition, and NFPA 110 Standard for Emergency and Standby Power Systems 2010 Edition. This deficient practice has the potential to impact 109 of 109, residents as well as an indeterminable number of staff and visitors. Findings are as follows: NFPA 110 2010 Edition states in part,	K0353 K0918	**As a POC for Tag K918:** **IMMEDIATE ACTION:** There were no residents identified in this tag. **ID OF OTHERS:** Although there were no residents identified in this tag, we recognize the potential risk to residents and others associated with the lack of compliance ensuring the generator is able to handle 30% load of the name plate rating. We have corrected this issue. **SYSTEM CHANGES/EDUCATION:** The facility's service provider. [redacted] was contacted on 8/11/25 to provide maintenance and repairs to our generator. The maintenance director has created a monthly generator testing log to maintain generator testing information. Monthly generator testing will be completed per regulations.	8/28/25

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K0918 SS = F Bldg. 01	Continued from page 6 "...8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. 8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent [%] of the EPSS nameplate kW [kilowatt] rating..." Record review of the monthly maintenance report for the EPSS generator on 8/13/2025, revealed the facility failed to provide documentation with proper calculations of the load on the generator during the load test to determine if the generator was meeting the 30% load of the name plate rating, for 12 out of 12 months reviewed. During a surveyor interview with the Maintenance Director on 8/14/2024 at 2:30 PM, he was unable to provide evidence that the EPSS generator was being exercised under a load that is greater than, or equal to, 30% of the name plate kW rating of the generator, as required.	K0918	**AUDITS:** The Director of Maintenance will report to the QAPI Committee each month to make them aware of the status of the required fire protection equipment inspections including proper generator functioning and maintenance that are needed and/or in progress. The QAPI Committee will review this issue for a period of no less than three months after which time, they will re-evaluate the frequency of review of this Life Safety element. 8/28/25 8/28/25	8/28/25

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Center for Health Facilities and Regulation on 8/13/2025 through 8/14/2025. The facility was found to be in compliance with 42 CFR §483.73 related to Emergency Preparedness. Census-109 Capacity-129	E0000		

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