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

PRINTED: 04/01/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415078	A. BUILDING _____ B. WING _____	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESPIRATORY AND REHABILITATION CENTER OF RI	10 WOODLAND DRIVE COVENTRY, RI 02816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey and complaint survey, ACTS reference numbers 99941 and 99942 were conducted at Respiratory and Rehabilitation Center of Rhode Island Nursing Home on 3/18/2025 through 3/21/2025 to determine compliance with 42 C.F.R. Part 483, requirements for Long Term Care Facilities. A state licensure and emergency preparedness surveys were also conducted at this facility. Deficiencies were identified as a result of this survey.	F 000	Respiratory and Rehab center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of corrections is prepared and executed solely because it is required by federal and state law. Received APR 09 2025 Facilities Regulation	04/17/25
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has	F 552	Resident #101. Residents remain in the facility with no ill effect. All residents have potential to be affected by this deficient practice Education will be provided to all licensed nurses on inform consent Facility wide audit will be conducted on all residents on antipsychotic If consent was provided. Also all new admission on antipsychotic will be provided inform consent form. This audit will be completed weeklyx4 and monthlyx2 until compliance is met The result of this audit will be submitted at QAPI Responsible Party: Don/Designee.	

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

Any deficiency statement ending with an asterisk(*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 552	Continued From page 1 been determined that the facility failed to inform the resident's appointed representative, in advance, of the care to be furnished by the physician or other provider, of the risks and benefits of proposed care or treatment alternatives relative to the ordering of, and administration of, an antipsychotic medication for 1 of 2 residents reviewed for the use of Rexulti (an atypical antipsychotic medication), Resident ID #101. Findings are as follows: Review of a community reported complaint submitted to the Rhode Island Department of Health on 3/17/2025 alleges that the resident was started on Rexulti in January of 2025 and the resident was unable to provide consent. Additionally, a family member was never contacted about the addition of Rexulti nor advised of any risks or adverse reactions related to its use. Review of the facility policy titled, "... Informed Consent" last reviewed 2/1/2023 states in part, "... Informed consent will be obtained from the patient or resident representative for all medical ... high risk treatments ... Evidence that informed consent has been obtained will be documented in the medical record ... to ensure that the patient and/or representative has been apprised of the risks, benefits, and the alternatives related to ... any high risk treatment..." Review of the manufacturer's insert for Rexulti revised in July of 2015, revealed the following warning and precautions with Rexulti use for elderly individuals with dementia related psychosis:	F 552		

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F 552	Continued From page 2 - Increased risk of death - Increased risk of stroke Record review revealed the resident was readmitted to the facility in November of 2024 with a diagnosis including, but not limited to, dementia with psychotic disturbance. Review of a Minimum Data Set Assessment dated 1/10/2025 revealed a Brief Interview for Mental Status score of 3 out of 15, indicating severe cognitive impairment. Review of a document titled, "RESIDENT REPRESENTATIVE DESIGNATION" dated 10/14/2024 revealed that the resident appointed a family member to act on behalf of him/her in order to support his/her decision-making, which was signed by the resident, the resident's appointed family member, and a facility representative. Review of a progress note dated 1/15/2025, authored by the Physician Assistant, revealed that the resident has dementia and continues to have intermittent behaviors and baseline confusion. Additionally, an order for Rexulti 0.5 milligrams (mg) for 7 days was placed and was to be reevaluated for a continuance or increase in the medication. Further, it failed to reveal evidence that resident's representative was informed regarding the addition of Rexulti or the risks, benefits, and alternatives to the medication. Review of the January 2025 Medication Administration Record (MAR) revealed that the resident received Rexulti 0.5 mg daily from 1/16/2025 through 1/21/2025.	F 552		

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F 552	Continued From page 3 Review of a progress note dated 1/21/2025 authored by the Physician Assistant, revealed that the resident was seen at the request of the nursing staff due to the continuance of behaviors. Additionally, his/her Rexulti 0.5 mg dose was discontinued, and s/he was to start Rexulti 1 mg daily. Further, it failed to reveal evidence that the resident's representative was informed regarding the dosage change to his/her Rexulti or the risks, benefits, and alternatives to the medication. Additional review of the January 2025 MAR revealed that the resident received Rexulti 1 mg daily from 1/22/2025 through 1/28/2025. Review of a progress note dated 1/29/2025 authored by the Physician Assistant, revealed that the resident was seen at the request of the nursing staff and for the reevaluation of his/her Rexulti use. Additionally, his/her Rexulti 1 mg dose was discontinued, and s/he was to start Rexulti 2 mg daily. Further, it failed to reveal evidence that resident's representative was informed regarding the dosage change to his/her Rexulti or the risks, benefits, and alternatives to the medication. Review of the January and February 2025 MAR revealed that the resident received Rexulti 2 mg daily on 1/30/2025 and 1/31/2025, and 2/1/2025 through 2/21/2025. Record review failed to reveal evidence that the resident's representative was informed, in advance, of the addition of Rexulti to the resident's medication regimen or subsequent dosage changes, or informed of the risks and benefits of Rexulti or treatment alternatives.	F 552		

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F 552	Continued From page 4 During a surveyor interview on 3/21/2025 at 12:53 PM with the Director of Nursing Services, he revealed that he would have expected the nurse to discuss the addition of Rexulti to the resident's treatment plan or any changes made to the treatment plan with the resident's representative and document it in a progress note.	F 552		
F 568 SS=E	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to ensure that each resident was given a written accounting of his/her deposits, withdrawals, and balances at least quarterly for 5 of 7 residents reviewed, Resident ID #s 36, 41, 58, 69, and 252. Findings are as follows: 1. Record review revealed that Resident ID #36 was admitted to the facility in February of 2017.	F 568	Resident #36,#41,#58 and #69 remain in the facility. All residents have potential to be affected by this deficient practice. Education will be provided to all BOM on resident's fund quarterly statement expectation. Facility wide audit will be conducted on all residents that facility manage their funds. This audit will be completed quarterly and annually until compliance is met. Result of this audit will be submitted at QAPI Responsible Party: Admin/Designee.	

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F 568	Continued From page 5 Review of a facility provided document titled, "Trial Balance" dated 3/18/2025, revealed that Resident ID #36 has funds being held by the facility. Record review failed to reveal evidence of a quarterly statement for Resident ID #36. 2. Record review revealed that Resident ID #41 was readmitted to the facility in December of 2023. Review of a facility provided document titled, "Trial Balance" dated 3/18/2025, revealed that Resident ID #41 has funds being held by the facility. Record review failed to reveal evidence of a quarterly statement for Resident ID #41. 3. Record review revealed that Resident ID #58 was readmitted to the facility in February of 2024. Review of a facility provided document titled, "Trial Balance" dated 3/18/2025, revealed that Resident ID #58 has funds being held by the facility. Record review failed to reveal evidence of a quarterly statement for Resident ID #58. 4. Record review revealed that Resident ID #69 was readmitted to the facility in January of 2025. Review of a facility provided document titled, "Trial Balance" dated 3/18/2025, revealed that Resident ID #69 has funds being held by the facility.	F 568		

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F 568	Continued From page 6 Record review failed to reveal evidence of a quarterly statement for Resident ID #69. 5. Record review revealed that Resident ID #252 was readmitted to the facility in February of 2025. Review of a facility provided document titled, "Trial Balance" dated 3/18/2025, revealed that Resident ID #252 has funds being held by the facility. Record review failed to reveal evidence of a quarterly statement for Resident ID #252. During a surveyor interview on 3/20/2025 at 9:21 AM, with the Business Office Manager, she acknowledged that the above residents had not been provided a written accounting of his/her deposits, withdrawals, and balances at least quarterly per the regulation. During a surveyor interview on 3/20/2025 at approximately 10:30 AM, with the Administrator, she was unable to provide evidence that the facility provided quarterly statements for the above-mentioned residents for 2024.	F 568		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.1 0(g)(17)(18)(i)-(v) §483.1 0(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the	F 582	Resident #93 remains in facility. All residents have potential to be affected by this deficient practice Education was provided to MDS, social worker nurses on issuing NOMNC/ SNFABN for resident discharge from Med A and manage care service.	

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F 582	Continued From page 7 facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on	F 582	A facility wide audit will be conducted on all Med A and manage care residents also on all new admissions that are Med A and manege care. This audit will be completed weeklyx4 and monthlyx2 until compliance is met Result of this audit will be submitted at QAPI Responsible party: BOM/Designee	

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F 582	Continued From page 8 behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to properly provide notice to residents and/or representatives informing them of when changes in coverage are made to items and services covered by Medicare and/or the state medical plan related to the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) of Non-coverage Form for 2 of 4 residents discharged from Medicare Part A Services that remained in the facility, Resident ID #s 64 and 402. Additionally, the facility failed to provide notice of Medicare Non-Coverage (NOMNC), in a timely manner for 2 of 4 residents reviewed who were discharged from a Medicare covered Part A stay with benefit days remaining, Resident ID #s 93 and 253. Findings are as follows: 1. Review of the Center for Medicare and Medicaid Services (CMS) Form, CMS 100-55, titled "Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage," states in part: "Medicare requires SNFs [Skilled Nursing Facilities] to issue the SNFABN to Original Medicare, also called fee-for-service **(FFS)** beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is: - not medically reasonable and necessary. - or considered custodial.	F 582		

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F 582	Continued From page 9 The SNFABN provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. SNFs must use the SNFABN when applicable for SNF Prospective Payment System services (Medicare PartA)..." 1a. Record review revealed that Resident ID #64's last covered day of Medicare Part A Services was on 12/5/2024. Further record review failed to reveal evidence that the resident and/or resident representative was issued the SNFABN form. 1b. Record review revealed that Resident ID #402's last covered day of Medicare Part A Services was on 12/21/2024. Further record review failed to reveal evidence that the resident and/or resident representative was issued the SNFABN form. 2. Review of the Center for Medicare and Medicaid Services (CMS) Form, CMS-10123, titled "Form Instructions for the Notice of Medicare Non-Coverage (NOMNC)," states in part, "...A Medicare provider or health plan (Medicare Advantage plans and cost plans, collectively referred to as "plans") must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services. The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to	F 582		

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F 582	Continued From page 10 last day of service if care is not being provided daily..." 2a. Record review revealed that Resident ID #93's last covered day of Medicare Part A Services was on 2/12/2025. Further record review failed to reveal evidence that the resident and/or resident representative was issued the NOMNC form. 2b. Record review revealed that Resident ID #253's last covered day of Medicare Part A Services was on 1/13/2025. Further record review failed to reveal evidence that the resident and/or resident representative was issued the NOMNC form. During a surveyor interview on 3/20/2025 at 12:30 PM, with the Business Office Manager, she revealed that Resident ID #s 64 and 402 should have been issued the SNFABN form and was unable to provide evidence that the SNFABN form was completed. Additionally, she acknowledged that Resident ID #s 93 and 253 should have been provided with a NOMNC and was unable to provide evidence that the resident and/or resident representative was issued the NOMNCform. During a surveyor interview on 3/20/2025 at 12:59 PM, with the Administrator, she was unable to provide evidence that the facility provided the SNFABN notice for Resident ID #s 64 and 402 and was unable to provide evidence that the resident and/or resident representative was issued the NOMNC form for Resident ID #s 93 and 253.	F 582		

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F 600 SS=D	Free from Abuse and Neglect CFR(s): 483, 12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483, 12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, resident, and staff interview, it has been determined that the facility failed to keep a resident free from neglect for 1 of 1 resident reviewed for activities of daily living (ADLs), Resident ID #452. Findings are as follows: Review of a facility policy titled, "Abuse Prohibition" last reviewed on 2/23/2021 states, in part, "... Neglect is defined as the failure of the Center, its employees, or service providers to provide goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress,,," Review of a facility policy titled, "...Activities of Daily Living (ADLs)" last revised 5/1/2023 states in part, "...Activities of daily living (ADLs) include:	F 600	Resident #452 still remain in facility free of abuse and satisfied with care provided. All residents have potential to be affected by this deficient practice Education provided to all staff on abuse, neglect, Adls and call light. Facility wide audit will be conducted on all residents Adl's, call light to ensure all residents are free from abuse and their Adl's needs a.re met This audit will be completed weeklyx4 and monthlyx2 until compliance is met Result of this audit will be submitted at QAPI. Responsible Party: Don/Designee.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415078	A. BUILDING _____ B. WING _____	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESPIRATORY AND REHABILITATION CENTER OF RI	10 WOODLAND DRIVE COVENTRY, RI 02816

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F 600	Continued From page 12 Hygiene - bathing, dressing, grooming, and oral care; Mobility - transfer and ambulation, including walking; Elimination - toileting...A patient who is unable to carry out ADLs will receive the necessary level of AOL assistance to maintain good nutrition, grooming, and personal and oral hygiene... Documentation of AOL care is recorded in the medical record and is reflective of the care provided by the nursing staff...ADL care will be documented in real time, as close to the time that care was provided...ADL care is documented every shift by the nursing assistant..." Record review revealed Resident ID #452 was admitted to the facility on 3/13/2025 with diagnoses including, but not limited to, anxiety, recurrent depressive disorders, and urinary tract infection. Review of a document completed on 3/13/2025, the resident's day of admission, revealed that s/he is "Alert oriented x 3" indicating that s/he is alert and orientated to person, place, and time. Review of an occupational therapy document dated 3/14/2025 revealed that s/he requires moderate assistance for grooming and max assistance to bathe/dress his/her upper body. Additionally, s/he requires total dependence to bathe/dress his/her lower body, toileting, and transfers. Review of his/her care plan revealed a focus area dated 3/14/2025 indicating that the resident is at risk for decreased ability to perform ADLs including, but not limited to, grooming, personal hygiene, dressing, and toileting. a. Record review revealed that the resident was	F 600		

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F 600	Continued From page 13 being treated with anti-fungal powder to his/her peri area twice daily and as needed. The order was changed to three times daily on 3/17/2025. Further, it revealed thats/he is incontinent of urine. During a continuous surveyor observation and simultaneous interview on 3/18/2025 at approximately 11:20 AM, with the resident, s/he was observed in his/her room seated in a wheelchair adjacent to his/her bed and was wearing a hospital gown. S/he revealed that the staff take a long time to respond to the call light and that the nursing assistants do not provide AOL care for him/her, only the therapists do. S/he further revealed that a nursing assistant (NA) had come into his/her room earlier only to make the bed, buts/he had not been provided assistance with washing or dressing. At the surveyor's request, s/he triggered the call light response system at 11:22 AM. Approximately 2 minutes later, an unidentified staff member answered the call light via the telecom system. The resident informed this staff member thats/he needed his/her brief changed. The staff member indicated that they would inform therapy sos/he could be transferred back to bed then s/he could be changed. At 11:55 AM, approximately 30 minutes later, the resident indicated to the surveyor that s/he needed to be changed as s/he could not wait any longer because s/he was being treated for a rash in his/her peri area and was uncomfortable, and again, triggered the call light at the surveyor's request. At 11:56 AM, a respiratory therapist entered his/her room and indicated to the resident that she would inform the resident's NA thats/he needed to be changed. At 11:58 AM, 2 NAs, Staff A and Staff B, entered his/her room and indicated to the resident, with the surveyor present, that	F 600		

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F 600	Continued From page 14 they could not change him/her until therapy transferred him/her back to bed first. During a surveyor interview immediately following the above observation with Staff A and Staff B, they revealed that they are not able to transfer the resident because s/he is "still being evaluated by therapy." They further revealed that neither of them had answered the resident's call light via the telecom system at 11:22 AM and indicated that NAs do not respond to the call light telecom system, are unable to shut off the call light via the telecom system, and staff must physically turn off the call light in the resident's room. Additionally, Staff B informed the surveyor that s/he had physically responded to the resident's call light only a few minutes earlier, however the surveyor had continuously observed the resident and did not observe Staff B to have physically responded to his/her call light minutes earlier as Staff B indicated. During a subsequent surveyor observation on 3/18/2025 at 12:03 PM, Physical Therapist, Staff C, was observed to enter the resident's room and transfer the resident back to bed from his/her wheelchair. Additionally, at approximately 12:10 PM, Staff A and Staff B entered the resident's room to provide incontinence care for the resident, approximately 48 minutes after the resident initially triggered his/her call light and informed staff that s/he needed his/her brief changed. During a surveyor interview on 3/18/2025 at approximately 12:10 PM with Staff C, following the above observation, he revealed that there are no restrictions for the NAs to transfer the resident, and s/he does not require a therapist's	F 600		

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F 600	Continued From page 15 assistance for transfers. During a surveyor interview on 3/18/2025 at 12:18 PM with Registered Nurse, Staff D, she revealed that she is the nurse assigned to care for the resident. She further revealed that the resident has been working with therapy and the resident requires max assistance for transfers and would expect the nursing assistants to transfer the resident from his/her wheelchair back to his/her bed to provide incontinence care. Additionally, she revealed that the resident has a painful fungal rash to his/her peri area and the provider recently changed the treatment from twice daily to three times daily and as needed. Furthermore, she indicated that the NAs primarily answer the call light telecom system located at the desk, and that they are able to turn off a call light via the telecom system. b. During a surveyor observation and simultaneous interview on 3/18/2025 at approximately 11:20 AM with the resident, s/he was observed in his/her room seated in a wheelchair adjacent to his/her bed and was wearing a hospital gown. S/he revealed that an NA had come into his/her room earlier only to make the bed, but s/he had not been provided assistance with washing or dressing and would like to be washed and dressed. S/he further revealed that a therapist had come in earlier that morning and provided incontinence care and conducted a brief therapy session, but did not assist him/her with washing or dressing. During a surveyor interview on 3/18/2025 at approximately 12:00 PM with Staff A and Staff B, they revealed that neither of them were assigned to care for the resident on 3/18/2025 during the	F600		

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F 600	Continued From page 16 7:00 AM - 3:00 PM shift, and indicated that the resident was on NA, Staff E's, assignment. During a surveyor interview on 3/18/2025 at 12:18 PM, with the resident's nurse, Staff D, she revealed that she would have expected that the resident's AOL care to have already been completed by this time. During a surveyor interview on 3/18/2025 at 12:26 PM, with Staff E, he revealed that he was unaware that he was assigned to provide care for the resident on 3/18/2025 on the 7:00 AM - 3:00 PM shift. Additionally, after reviewing the NA assignment sheet with him, he acknowledged that he was the NA responsible for providing care for the resident that day. During subsequent observations and simultaneous interviews on 3/18/2025 at 2:11 PM and 3:04 PM with the resident, s/he was observed still in his/her bed in a hospital gown. S/he revealed that s/he was not provided any assistance with personal hygiene, assistance with being washed or dressed and was unsure of who his/her NA was during the 7:00 AM - 3:00 PM shift. During a surveyor interview on 3/18/2025 at 3:07 PM with Staff E, he revealed that he did not provide any assistance with ADLs for the resident on 3/18/2025 on the 7:00 AM to 3:00 PM shift because it was completed by a therapist. During a surveyor interview on 3/18/2025 at 3:10 PM with Occupational Therapist, Staff F, he revealed that on 3/18/2025 during the 7:00 AM to 3:00 PM shift, he set the resident up for mouth care and provided incontinence care, but did not	F 600		

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F 600	Continued From page 17 assist him/her with washing, grooming, or dressing. Record review failed to reveal evidence that the resident received assistance with AOL care, personal hygiene or dressing on 3/18/2025 during the 7:00 AM - 3:00 PM shift even after the surveyor's concern for the resident's care was brought to the facility's attention. During a surveyor interview on 3/19/2025 at approximately 11:00 AM with the Director of Nursing Services, he revealed that he would have expected the NAs to have transferred the resident back to bed to provide incontinence care. Additionally, he revealed that all residents should receive assistance with AOL care as needed and it should be documented accordingly.	F 600		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(9) §483.20(9) Accuracy of Assessments. The assessment must accurately reflect the resident's status. 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 the assessment accurately reflected the resident's status for 1 of 1 resident reviewed with a diagnosis of schizophrenia, Resident ID #66. Findings are as follows: Review of the "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual" last revised in October of 2024 states in part, "Code diseases that have a documented diagnosis in	F 641	Resident # 66 remain in facility, MDS will be modified. All residents have potential to be affected by this deficient practice. Education will be provided to all licensed nurses on inform consent. Facility wide audit will be conducted to make sure all residents are coded appropriately. This audit will be completed weeklyx4 and monthlyx2 until compliance is met Result of this audit will be submitted at QAPI. Responsible Party: Don/Designee.	

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F 641	Continued From page 18	F 641		

the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period ..."

Record review revealed Resident ID #66 was admitted to the facility in February of 2024 with a diagnosis including, but not limited to, bipolar disorder.

Record review revealed a Preadmission Screening and Resident Review (PASRR) dated in January of 2024, with a diagnosis of bipolar disorder. Further review of the document revealed that schizophrenia was not a documented diagnosis.

Review of an Admission MDS Assessment dated 2/7/2024, Section I, titled, "Active Diagnoses in the Last 7 Days" revealed the resident was not coded with an active diagnosis of schizophrenia.

Review of the following MDS Assessments, Section I, titled, "Active Diagnoses in the Last 7 Days" revealed the resident was coded with an active diagnosis of schizophrenia:

-5/9/2024
-7/11/2024
-10/9/2024
-1/9/2025

During a surveyor interview on 3/20/2025 at 3:08 PM, with the MDS Coordinator, she revealed that the schizophrenia diagnosis was added to the resident's medical record in May of 2024, prior to her starting in the MDS Coordinator position and was unaware of where it came from. Additionally,

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F 641	Continued From page 19 she acknowledged that she did code it on the 1/9/2025 assessment without any supporting documentation. During a surveyor interview on 3/21/2025 at 11:04 AM, with the Physician Assistant in the presence of the Administrator, he revealed that he obtained the schizophrenia diagnosis from facility documentation or a consult but was unable to provide evidence of documentation that supports a diagnosis of schizophrenia for Resident ID #66. During a surveyor interview on 3/21/2025 at 11: 15 AM, with the Administrator, she acknowledged that the above MDS assessments included a diagnosis of schizophrenia without any supporting documentation.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21 (b)(2)(i)-(iii) §483.21 (b) Comprehensive Care Plans §483.21 (b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657	Resident #21 resident remain in facility, she's stable and free from injury. All residents have potential to be affected by this deficient practice. The AdHOC meeting was held with the IDT team to review resident care plans. Fall care plans were updated and modified. Also, all residents at risk of falling, their care plan was reviewed, update and modify. This audit will be completed weeklyx4 and monthlyx2 until compliance is met. Result of this audit will be submitted at QAPI Responsible Party: Don/Designee.	

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F 657	Continued From page 20 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to implement and revise a care plan after each assessment for 1 of 2 residents reviewed for falls, Resident ID #21. Findings are as follows: Review of a facility policy titled "Falls Management" last revised on 3/15/2024 states in part, "...Implement and document patient centered interventions according to individual risk factors in the patients care plan..." Record review revealed Resident ID #21 was readmitted to the facility in April of 2024, with diagnoses including, but not limited to, dementia, difficulty walking, and unsteadiness on feet. Record review revealed the following: -1/5/2025 - The resident sustained an unwitnessed fall, s/he was found lying on his/her back on the floor in his/her room. Review of a care plan with a focused area for risk for injury related to falls, revealed an intervention initiated on 1/5/2025, for a bedside mat on floor to	F 657		

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F 657	Continued From page 21 right side of the bed at all times while resident is in bed. -2/11/2025 - The resident sustained an unwitnessed fall while attempting to get out of bed unassisted, fell hitting the left side of his/her face resulting in swelling to the left eye and bruising to his/her face. Review of the care plan failed to reveal evidence of a revised intervention after the residents fall on 2/11/2025. -2/12/2025 - The resident was found sitting on the mat next to his/her bed with his/her head resting on the mattress of the bed. Review of a care plan with a focused area for risk of falls revealed an intervention initiated on 2/13/2025 to implement frequent checks once s/he is in his/her bed. -3/20/2025- The resident sustained an additional unwitnessed fall, s/he reported s/he was attempting to get out of bed and fell. During a surveyor interview on 3/21/2025 at 9:24 AM, with Registered Nurse, Staff G, she revealed that she was unaware that the care plan was not revised with a new intervention for the addition fall on 2/11/2025. Additionally, she was unable to provide evidence that the fall risk intervention added on 2/13/2025, to implement frequent checks when the resident is in his/her bed, had been implemented. During a surveyor interview on 3/21/2025 at 10:25 AM with the Director of Nursing Services, he acknowledged that the residents care plan failed	F 657		

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F 657	Continued From page 22 to reveal evidence of a revised intervention after his/her subsequent fall on 2/11/2025. Additionally, he was unable to provide evidence that the fall risk intervention added on 2/13/2025, to implement frequent checks when the resident is in his/her bed, had been implemented.	F 657		
F 658 SS=E	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 meet professional standards of quality relative to failure to follow a physician's order for 1 of 1 resident reviewed for daily weights, Resident ID #23. Findings are as follows: According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states in part, "...The physician is responsible for directing medical treatment, Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients..." Record review revealed the resident was admitted to the facility in February of 2022 with diagnoses including, but not limited to, chronic obstructive pulmonary disease (a lung condition caused by damage to the lungs) and type 2 diabetes mellitus with diabetic chronic kidney disease (when the kidneys are damaged over	F658	Resident # 23 resident remain in facility with no adverse effect. All residents have potential to be affected by this deficient practice Education will be provided to all licensed nurses on physician's order. Facility wide audit will be conducted on all dialysis resident This audit will be completed weeklyx4 and monthlyx2 until compliance is met Result of this audit will be submitted at QAPI Responsible Party: Don/Designee	

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RESPIRATORY AND REHABILITATION CENTER OF RI	10 WOODLAND DRIVE COVENTRY, RI 02816

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F 658	Continued From page 23 time due to high blood sugar). Record review revealed an active physician's order with a start date of 7/31/2024, that states "daily weights in the morning for monitoring." Record review failed to reveal evidence that daily weights were obtained between 7/31/2024 through 3/21/2025. During a surveyor interview on 3/20/2025 at 8:51 AM, with Registered Nurse, Staff G, she indicated that she was unaware that Resident ID #23 had an active physician's order for daily weights. She further revealed that daily weights had not been obtained between 7/31/2024 through 3/21/2025. During a surveyor interview on 3/20/2025 at approximately 10:30 AM with the Dietitian, she revealed that she was unaware of the active physician order for daily weights that was ordered on 7/31/2024. During a surveyor interview on 3/21/2025 at 10:47 AM with the Director of Nursing Services, he acknowledged that the resident had an active physician order for daily weights ordered on 7/31/2025, and he revealed it would be his expectation for the weights to have been obtained as ordered.	F658		
F 698 SS=D	Dialysis CFR(s): 483.25(1) §483.25(1) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and	F 698		

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F 698	Continued From page 24 the residents' goals and preferences. 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 residents who require dialysis (a treatment that removes excess fluid, waste, and toxins from the blood when the kidneys are no longer functioning properly) receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 1 resident reviewed for communication with the dialysis center, Resident ID#64. Findings are as follows: Review of a facility policy titled, "Dialysis: Hemodialysis [HD]..." states in part, "... Shared Communication Between the Center and the Certified ESRD [End-stage renal disease] Facility... Communication topics... Declines in functional status, falls, the identification of symptoms such as anxiety, depression, confusion... Changes and/or decline in conditions unrelated to HD..." Record review revealed that Resident ID #64 was readmitted to the facility in February of 2025, with a diagnosis including, but not limited to, ESRD. Record review revealed that the resident attends dialysis three times a week on Monday, Wednesday, and Friday. Record review of a provider note dated 3/11/2025, authored by the Physician Assistant states in part, "...GI bleed [gastrointestinal	F 698	Resident #64 resident remain in facility with no negative outcome All residents have potential to be affected by this deficient practice Education will be provided to all licensed nurses on proper communication with the receiving center of any change in resident conditions. Also, upon returning the receiving nurse to read any communication from dialysis. Facility wide audit will be conducted on all dialysis residents to ensure effective communication. This audit will be completed on respective dialysis day weeklyx4 and monthlyx2 until compliance is met. The result of this audit will be presented at QAPI. Responsible Party: DON/Designee	

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F 698	Continued From page 25 bleed]... Nurse staff reports bright red blood per rectum... Patient adamantly declines emergency room evaluation. Order placed for blood work..Patient in the past been seen in emergency room for GI bleed requiring transfusion..." Review of the dialysis communication binder, communication sheets, and record failed to reveal evidence that the facility notified the dialysis center of the resident's GI bleed. Record review of a progress note dated 3/13/2025, authored by the Physician Assistant revealed that the resident had a witnessed fall on 3/12/2025 with two nursing assistants during a transfer to his/her wheelchair. Additionally, the provider ordered that all transfers require a Hoyer lift (a mechanical lift, a device designed to assist caregivers in safely transferring patients) and instructed staff to contact dialysis and provide an update as to his/her current medical standing. Review of the dialysis communication binder, communication sheets, and record failed to reveal evidence that the facility notified the dialysis center of the resident's fall and change in transfer status. During a surveyor interview on 3/20/2025 at 8:59 AM, with Registered Nurse, Staff H, she revealed that the resident sustained a fall on 3/12/2025. Additionally, she revealed that she was unaware that the facility policy states to notify the dialysis center with changes such as a change in condition or falls and stated, "any information that the facility would send would be included in the dialysis binder."	F 698		

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F 698	Continued From page 26 During a surveyor interview on 3/20/2025 at 11:37 AM, with the Director of Nursing Services, he acknowledged that the resident's communication binder, communication sheets, and record failed to reveal evidence that the facility notified the dialysis center of the resident's GI bleed, fall, and change in transfer status. Additionally, he revealed that he was unaware that the facility had to notify the dialysis center of a fall, although the facility policy states to do so.	F 698		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any,	F 756	Resident #93 resident remain in facility with no negative outcome. All residents have potential to be affected by this deficient practice Education will be provided to all licensed nurses on medication reconciliation A facility wide audit will be conducted on all residents on antibiotic This audit will be completed weeklyx4 and monthlyx2 until compliance is met. Result of this audit will be submitted at QAPI Responsible Party: Don/Designee.	

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F 756	Continued From page 27 action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. 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 the irregularities identified by the Consultant Pharmacist during the monthly pharmacist Medication Regimen Review (MRR) were acted upon for 1 of 2 residents reviewed for admission medication reconciliation, Resident ID #93. Findings are as follows: Record review revealed that the resident was admitted to the facility in January of 2025 with diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD, a lung condition caused by damage to the lungs.) and bacterial pneumonia. Record review revealed the following physician's orders: -1/7/2025 prednisone (a medication prescribed to decrease inflammation) 40 milligrams (mg), give one tablet once daily for COPD -1/7/2025 doxycycline (a medication prescribed to	F 756		

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F 756	Continued From page 28 treat infection), 100 mg, give one tablet two times daily for pneumonia Record review of a new admission MRR form dated 1/8/2025, authored by the pharmacist, revealed a recommendation to the facility to clarify a stop date for the doxycycline. Additionally, the review indicates to clarify a stop date or taper order (a gradual reduction of a medication over time until discontinued) for the prednisone order. Record review of a MRR dated 1/22/2025 revealed a repeat recommendation to clarify the doxycycline order with a stop date. Record review of a MRR dated 2/27/2025 revealed a repeat recommendation to clarify a stop date or taper order for the prednisone. Review of the January, February, and March 2025 Medication Administration Records (MAR) revealed that the resident was administered the doxycycline on the following dates: -1/7/2025, through 3/19/2025, twice daily for a total of 141 doses. Further review of the January, February, and March 2025 MAR revealed that the resident was administered the prednisone on the following dates: -1/8/2025, through 3/19/2025, once daily for a total of 71 doses. During a surveyor interview on 3/21/2025 at 10:15 AM with the Director of Nursing Services, he was unable to provide evidence that the residents	F 756		

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F 756	Continued From page 29 MRR recommendations were acted upon. During a surveyor interview on 3/21/2025 at 4: 16 PM via the telephone with the resident's Physician he indicated it would be his expectation for the prednisone to have been tapered and the doxycycline to have been stopped per the pharmacist's recommendations. Cross Reference F 757 and F 881.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has	F 757	Resident #93 resident remain in facility with no negative outcome. All residents have potential to be affected by this deficient practice Education will be provided to all licensed nurses on medication regime review A facility wide audit will be conducted on all residents on antibiotic and prednisone This audit will be completed weeklyx4 and monthlyx2 until compliance is met. Result of this audit will be submitted at QAPI Responsible Party: Don/Designee.	

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F 757	Continued From page 30 been determined that the facility failed to ensure that the resident's drug regimen is free from unnecessary drugs for 1 of 2 residents reviewed for admission medication reconciliation, Resident ID#93. Findings are as follows: Record review revealed that the resident was admitted to the facility in January of 2025 with diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD, a lung condition caused by damage to the lungs) and bacterial pneumonia. Record review of a "Continuity of Care Discharge/Transfer of Patient Form" (COC) dated 1/1/2025 revealed an attached communication form titled "Discharge summary" with the following physician's orders: -prednisone 40 milligrams (mg), give one tablet once daily for 4 days, which indicates the medication would be discontinued on 1/5/2025. -doxycycline 100 mg, give one tablet two times daily for 2 days which indicates the medication would be discontinued on 1/3/2025. Record review revealed the following physician's orders: -1/7/2025 prednisone 40 mg, give one tablet once daily for COPD -1/7/2025 doxycycline 100 mg, give one tablet two times daily for pneumonia Review of the January, February, and March	F 757		

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F 757	Continued From page 31 2025 Medication Administration Records (MAR) revealed that the resident was administered the doxycycline on the following dates: -1/7/2025 through 3/19/2025, twice daily for a total of 141 doses. Further review of the January, February and March 2025 MAR revealed that the resident was administered the prednisone on the following dates: -1/8/2025 through 3/19/2025, once daily for a total of 71 doses. Record review of a new admission medication record review (MRR) form dated 1/8/2025, authored by the Pharmacist, revealed a recommendation to the facility to clarify a stop date for the doxycycline and a stop date or tapering order (a gradual reduction of a medication over time until discontinued) for the prednisone. Record review of an MRR dated 1/22/2025 revealed a repeat recommendation to clarify the doxycycline order with a stop date. Record review of an MRR dated 2/27/2025 revealed a repeat recommendation to clarify a stop date or taper for the prednisone. During a surveyor interview on 3/21/2025 at 10:15 AM with the Director of Nursing Services, he acknowledged that the COC from the resident's admission indicated the doxycycline and prednisone should have been discontinued prior to the resident's admission to the facility. He further indicated it would be his expectation that	F 757		

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F 757	Continued From page 32 the complete COC would have been reviewed during his/her admission medication reconciliation. Additionally, he was unable to provide evidence that the residents drug regimen was kept free from unnecessary drugs. During a surveyor interview on 3/21/2025 at 11:05 AM with the Physician Assistant he indicated he was not aware of the stop dates for both medications list on the admission COC. During a surveyor interview on 3/21/2025 at 4:16 PM via the telephone with the resident's Physician he indicated he would have expected the facility to follow the order to discontinue the medications listed on the COC. Additionally, he indicated that the doxycycline should have only continued for a few days and that the prednisone should have been tapered. Cross Reference F 756 and F 881.	F 757		
F 838 SS=D	Facility Assessment CFR(s): 483.71 (a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment.	F 838	Facility assessment has been completed Education has been provide to the Administrator, DON, by governing body to ensure timely completion of facility assessment at minimal annually and at any new changes. The facility assessment will be reviewed quarterlyx4 to assure that changes are reflected. The result of this audit will be presented at QAPI. Responsible Party: NHA/Designee.	

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F 838	Continued From page 33 §483.71(a) The facility assessment must address or include the following: §483.71 (a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or	F 838		

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F 838	Continued From page 34 training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71 (c) The facility must use this facility assessment to: §483.71 (c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and	F 838		

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F 838	Continued From page 35 plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71 (c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to document all required components of the facility-wide assessment. Additionally, the facility failed to review and update the assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. Findings are as follows: Review of an undated and unsigned facility document titled, "Facility Assessment," for the year of 2025, failed to reveal evidence of the	F 838		

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F 838	Continued From page 36 active involvement of the following participants in the process: 1. Nursing home leadership and management, including but not limited to, a member of the governing body, the Medical Director, an Administrator, and the Director of Nursing Services (DNS). Record review of the "Assessment Contributors" section, revealed of the 13 management staff listed including the Administrator, the DNS, and the Medical Director, 11 of them were no longer employed at the facility. 2. The facility must also solicit and consider input received from residents, resident representatives, and family members. Record review failed to reveal evidence that the facility solicited and considered input received from residents, resident representatives, and family members. During a surveyor interview on 3/20/2025 at 3:37 PM, with the Administrator, she was unable to provide evidence that the facility included all required components of the facility-wide assessment and completed any changes that would require a substantial modification to any part of this assessment as mentioned above.	F 838		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and	F 865	Resident #43,#64,#89,#92 and #93. Residents remain in facility and complete their antibiotic without any ill effect.	

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F 865	Continued From page 37 maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:	F 865	All residents have potential to be affected by this deficient practice The antibiotic stewardship was reviewed to ensure all elements are addressed. Education will be provided to Infection preventionist to assure when completing report related to antibiotic stewardship is thorough and include all the element of antibiotic stewardship. Quarterly audit will be completed x3 and annually until compliance is met. Result of this audit will be submitted at QAPI Responsible Party: Don/Designee.	

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F 865	Continued From page 38 §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and	F 865		

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F 865	Continued From page 39 other information. §483.75(1)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(1)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. 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 implement and maintain an effective, comprehensive, data-driven, Quality Assurance and Performance Improvement (QAPI) program that focuses on indicators of the outcomes of care and quality of life. Additionally, the facility failed to make a good faith attempt to correct the identified concern of antibiotic stewardship (the effort to measure and improve how antibiotics are prescribed by clinicians and used by patients) and personal protective equipment (PPE) related to enhanced barrier precautions (EBP; refers to an infection control intervention designed to reduce the transmission of multidrug-resistant organisms [MORO] that employs targeted gown and glove use during high contact resident care activities).	F 865		

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F 865	Continued From page 40 Findings are as follows: A. Record review of the document titled "Quality Assurance and Performance Improvement Projects (QAPI) Infection Control/Education Topic: HH [hand hygiene]/PPE", dated 11/12/2024 through 3/14/2025, revealed that, relative to infection control, the facility would be monitoring hand hygiene and PPE compliance. Further review failed to reveal evidence of implementation or maintenance of the plan, including tracking and measuring performance, and establishing goals and thresholds for performance measurements. During surveyor observations from 3/18/2025 through 3/20/2025, for Resident ID #s 15, 60, 74 and 92, revealed that staff were observed to have a breach in infection control practices related to staff failing to wear gowns during high contact care activities for a resident on EBP. B. Additional review of the document titled "Quality Assurance and Performance Improvement Projects (QAPI) Infection Control/Education Topic: Antibiotic Stewardship", revealed that, relative to infection control, the facility would be monitoring antibiotic stewardship compliance. Further review failed to reveal evidence of implementation or maintenance of the plan, including tracking and measuring performance, and establishing goals and thresholds for performance measurement. Record review for Resident ID #s 43, 64, 89, 92, and 93 failed to reveal evidence that antibiotic time outs were completed.	F 865		

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F 865	Continued From page 41 During a surveyor interview on 3/21/2025 at approximately 2:30 PM with the Director of Nursing Services and the Administrator, they were unable to provide evidence of a good faith attempt to correct the identified concerns brought forth related to EBP and antibiotic stewardship. Cross Reference F 880 and F 881.	F 865		
F 880 SS=E	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	F 880	Resident #15,#60, #74 and #92 resident remain in facility with no negative outcome All residents have potential to be affected by this deficient practice Immediate education was be provided to all staff upon identification on infection control. This audit will be completed weeklyx4 and monthlyx2 until compliance is met Result of this audit will be submitted at QAPI Responsible Party: Infection Preventionist /Designee.	

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F 880	Continued From page 42 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review,	F 880		

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F 880	Continued From page 43 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 enhanced barrier precautions (EBP; refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO] that employs targeted gown and glove use during high contact resident care activities), for 4 of 4 residents reviewed on EBP, Resident ID#s 15, 60, 74, and 92. Findings are as follows: Review of the facility signage titled "Enhanced Barrier Precautions" states in part, "...Wear Gown and Gloves prior to these activities ... Dressing ... bathing ... transferring ... providing hygiene ... Device care or use of a device (i.e. central lines (a long, flexible tube that inserted into a vein in the neck, chest, arm or groin, and passed through until it reaches a large vein near the heart), urinary catheters, feeding tubes, tracheostomies (an opening a surgeon makes through your neck and into your trachea [windpipe] to help you breathe), ventilators..." 1. Record review revealed Resident ID #15 was readmitted to the facility in March of 2024 with a diagnosis including, but not limited to, chronic respiratory failure with hypoxia (low levels of oxygen in the body). Record review revealed that Resident ID #15 requires EBP for a gastrostomy tube (G-tube; a tube inserted through the belly, providing direct access to the stomach), tracheostomy (trach) and a history of an MDRO.	F 880		

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F 880	Continued From page 44 During surveyor observations on 3/18/2025 and 3/19/2025, revealed signage posted outside of Resident ID #15's room for EBP. During a surveyor observation on 3/19/2025 at 9:33 AM, revealed Respiratory Therapist, Staff I, removing Resident ID #15's nebulizer treatment attached to his/her trach without wearing a gown per the facility signage. During a surveyor interview immediately following the above observation, with Staff I, she acknowledged that she failed to wear a gown per the signage. 2. Record review revealed Resident ID #60 was readmitted to the facility in September of 2024 with a diagnosis including, but not limited to, chronic obstructive pulmonary disease (COPD, a common lung disease causing restricted airflow and breathing problems). Record review revealed that Resident ID #60 requires EBP for a G-tube, Trach, urinary catheter, and a history of an MORO. During surveyor observations on 3/18/2025 and 3/19/2025, revealed signage posted outside of Resident ID #60's room for EBP. During a surveyor observation on 3/19/2025 at 9:50 AM, with Nursing Assistant (NA), Staff J, she was observed providing a bed bath for Resident ID #60 without wearing a gown per the facility signage. During a surveyor interview immediately following the above observation, with Staff J, she	F 880		

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F 880	Continued From page 45 acknowledged that she failed to wear a gown per the signage. 3. Record review revealed Resident ID #74 was readmitted to the facility in April of 2024 with a diagnosis including, but not limited to, chronic respiratory failure with hypoxia. Record review revealed that Resident ID #74 requires EBP for a G-Tube and Trach. During surveyor observations on 3/18/2025 and 3/19/2025, revealed signage posted outside of Resident ID #74's room for EBP. During a surveyor observation on 3/18/2025 at 9:55 AM with NA, Staff B, she was observed transferring Resident ID #74 from his/her bed to his/her chair. Staff B failed to wear a gown per the facility signage. During a surveyor interview immediately following the above observation, Staff B revealed that Resident ID #74 does not require the use of a gown for transfers as s/he is not on contact precautions, although the signage posted stated otherwise. During a surveyor observation on 3/19/2025 at 9:26 AM with NA Staff J, she was observed providing hygiene for Resident ID #74 without wearing a gown. During a surveyor interview immediately following the above observation, with Staff J, she acknowledged that she did not wear a gown per the facility signage and stated that Resident ID #74 did not require the use of a gown for hygiene.	F 880	Type text here	

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F 880	Continued From page 46 4. Record review revealed that Resident ID #92 was admitted to the facility in January of 2025, with a diagnosis including, but not limited to, chronic respiratory failure with hypoxia. Record review revealed that Resident ID #92 requires EBP for a G-tube, trach, and wounds. Additional record review revealed that Resident ID #92 has a central line. During surveyor observations on 3/18/2025, 3/19/2025, and 3/20/2025, revealed signage posted outside of Resident ID #92's room for EBP. During a surveyor observation on 3/20/2025 at approximately 8:24 AM, with Registered Nurse (RN), Staff K, she was observed to flush the resident's central line and connect the resident's antibiotic to the central line without wearing a gown. She was then observed to administer Resident ID #92 his/her medication via his/her G-Tube without wearing a gown. During a surveyor interview on 3/20/2025 at 9:18 AM, immediately following the above observations, Staff K revealed that she was unaware that Resident ID #92 was on EBP and that she was unsure if she should have worn a gown for G-tube or central line care. During a surveyor interview on 3/19/2025 at 11:45 AM with RN, Staff L, he revealed that when a resident has signage for EBP, he would expect staff to wear a gown when transferring, providing personal hygiene, bathing, trach care, G-Tube and central line medication administration.	F 880		

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F 880	Continued From page 47 During surveyor interviews on 3/20/2025 at 9: 10 AM and 3/21/2025 at 2:40 PM, with the Infection Preventionist, she revealed that she would expect staff to wear a gown when a resident is on EBP, for transferring, personal hygiene, bathing, trach care, G-Tube and central line medication administration. During a surveyor interview on 3/20/2025 at 9: 10 AM with the Director of Nursing Services, the Infection Preventionist, and the Administrator, they revealed that they would expect staff to follow the signage posted for residents on EBP. Cross Reference F 865.	F 880		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to establish an Infection Prevention and Control Program (IPCP) that must include, at a minimum, an antibiotic stewardship program which includes antibiotic use protocols and a system to monitor antibiotic use to ensure that residents who require an antibiotic, are prescribed the appropriate antibiotic for 2 of 5 residents reviewed for	F 881	Resident #93 and #89 residents remain in facility completed their antibiotic with no ill effect. All residents have potential to be affected by this deficient practice Education will be provided to the infection Preventionist on antibiotic stewardship program with it element. A facility wide audit will be conducted on all residents on antibiotic This audit will be completed weeklyx4 and monthlyx2 until compliance is met. Result of this audit will be submitted at QAPI Responsible Party: Infection DON/Designee.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415078	A. BUILDING _____ B. WING _____	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESPIRATORY AND REHABILITATION CENTER OF RI	10 WOODLAND DRIVE COVENTRY, RI 02816

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F 881	Continued From page 48 antibiotic orders, Resident ID #s 89 and 93. Findings are as follows: According to the Centers for Disease Control and Prevention (CDC) document titled, "The Core Elements of Antibiotic Stewardship for Nursing Homes" states in part, "Standardize the practices which should be applied during the care of any resident suspected of an infection or started on an antibiotic. These practices include improving the evaluation and communication of clinical signs and symptoms when a resident is first suspected of having an infection, optimizing the use of diagnostic testing, and implementing an antibiotic review process, also known as an "antibiotic time-out," for all antibiotics prescribed in your facility. Antibiotic reviews provide clinicians with an opportunity to reassess the ongoing need for and choice of an antibiotic when the clinical picture is clearer and more information is available ... Track the amount of antibiotic used in your nursing home to review patterns of use and determine the impact of new stewardship interventions ... Interventions designed to shorten the duration of antibiotic courses, or discontinue antibiotics based on post-prescription review (i.e., "antibiotic time-out"), may not necessarily change the rate of antibiotic starts, but would decrease the antibiotic DOT [days of therapy]. ." 1. Record review revealed that Resident ID #89 was admitted to the facility in January of 2025 with a diagnosis including, but not limited to, severe sepsis with septic shock. Record review revealed a physician's order for Levofloxacin (an antibiotic) tablet 750 mg give 1 tablet by mouth one time a day for prophylactics	F 881		

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F 881	Continued From page 49 with no end date. Record review failed to reveal evidence of an antibiotic review or an antibiotic time out. Record review revealed a physician's order for Meropenem-Sodium Chloride Intravenous Solution (an antibiotic) give 1 gram intravenously every 8 hours for left hip osteomyelitis (infection in the bone) with a start date of 1/30/2025 and an end date of 3/18/2025. Record review failed to reveal evidence of an antibiotic review or an antibiotic time out. 2. Record review revealed that Resident ID #93 was admitted to the facility in January of 2025 with a diagnosis including, but not limited to, bacterial pneumonia. Review of the hospital discharge summary dated 1/1/2025, which revealed an order for doxycycline (an antibiotic) give 100 mg by mouth two times a day for pneumonia for 2 days. Record review revealed a physician's order for doxycycline, give 100 mg by mouth two times a day for pneumonia for with a start date of 1/7/2025 without an end date. Review of the January 2025 Medication Administration Record, revealed a physician's order dated 1/13/2025 to follow-up with continuation of doxycycline 100 mg twice a day, documented as administered. During a surveyor interview on 3/21/2025 at 4:16 PM with Resident ID #93's Physician, he revealed that normally he would follow the hospital	F 881		

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F 881	Continued From page 50 discharge summary recommendations unless clinical presentation indicated to continue. Additionally, the facility was unable to provide evidence that the physician was notified of the discharge summary which resulted in the resident receiving the doxycycline 100 mg twice a day from 1/7/2025 through 3/19/2025 for a total of 141 doses and not the 4 doses as ordered on the discharge summary. During a surveyor interview on 3/21/2025 at 10:15 AM, with the Director of Nursing, he acknowledged that the doxycycline 100 mg had an end date indicated on the discharge summary. During multiple surveyor interviews with the Infection Preventionist on 3/20/2025 and 3/21/2025, she was unable to provide evidence of antibiotic time outs being completed for the above-mentioned residents. During a surveyor interview on 3/21/2025 at approximately 2:30 PM with the Director of Nursing Services and the Administrator they were unable to provide evidence that antibiotic time outs had been completed for the above-mentioned residents receiving antibiotics. Cross reference F 856 and F 757.	F 881		

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by the Center for Health Facilities and Regulation on 3/18/2025. The facility was found to be in compliance with 42 CFR §483.73 related to Emergency Preparedness. Capacity: 210 Census: 89	E 000		

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

Any deficiency statement ending with an asterisk(*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	INITIAL COMMENTS The annual Federal Life Safety Code survey was conducted by the State Survey Agency on 3/21/2025. Respiratory and Rehabilitation Center of RI 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: 210 Census: 89	K000		
K 324 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	K324	The facility failed to ensure the timeliness of the kitchen hood suppression system servicing. The Kitchen hood suppression system is schedule to be service by Cintas on 04/08/25 to maintain compliance. Education will be provided to maintenance staff to ensure the kitchen hood suppression is maintain regularly. Maintenance director will make sure the kitchen suppression is service on due date and will be recorded in maintenance log. This audit will be done Q6month The result will be presented at QAPI Responsible Party:Maintenance/Designee	

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

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K 324	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to maintain the kitchen's 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. This deficient practice has the potential to impact 89 of 89 residents, as well as an indeterminable number of staff and visitors. Findings are as follows: 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." Record review of the main building's kitchen suppression system service reports revealed that it was last serviced on 10/04/2024. The facility could not provide evidence the kitchen suppression system was serviced every 6 months, as required.	K324		

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K 324	Continued From page 2 During a surveyor interview with the Administrator and Maintenance Director on 3/21/2025 at 1:00 PM, they could not provide evidence for the semiannual kitchen suppression system inspections, as required.	K324		
K 353 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 NFPA25 This REQUIREMENT is not met as evidenced by: Based on record review, surveyor observation, and staff interview, it has been determined that the facility failed to ensure 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 Standard for the Inspection, Testing, and Maintenance of	K353	The facility failed to ensure timeliness of the automatic standpipe system flow test. The automatic standpipe flow is schedule to be service by Cintas on 04/08/25 to maintain compliance. Education will be provided to maintenance staff to ensure that the standpipe system is maintain regularly. The maintenance director will make sure the automatic standpipe system is service timely and it's recorded in the maintenance log book. This audit will be done annually. The result of the audit will be presented at QAPI Responsible Party: Maintenance/Designee.	

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K 353	Continued From page 3 Water-Based Fire Protection Systems 2011 Edition. This deficient practice has the potential to impact 89 of 89 residents as well as an indeterminable number of staff and visitors. Findings are as follows: NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 2011 Edition states in part, " ... Chapter 6 Standpipe and Hose Systems ... 6.3.1.1 * A flow test shall be conducted every 5 years at the hydraulically most remote hose connections of each zone of an automatic standpipe system to verify the water supply still provides the design pressure at the required flow ... 13.4.4 Dry Pipe Valves/ Quick-Opening Devices ... 13.4.4.2.2* Each dry pipe valve shall be trip tested annually during warm weather... 13.4.4.2.2.3* During those years when full flow testing in accord with 13.4.4.2.2.2 is not required, each dry pipe valve shall be trip tested with the control valve partially open... 14.2 Internal Inspection of Piping. 14.2.1...an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic	K353		

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K 353	Continued From page 4 material..." Record review of the automatic standpipe system reports failed to reveal evidence that a flow test was performed within the last 5 years. Further review revealed that the last flow test was completed on 3/10/2020. During a surveyor interview with the Maintenance Director on 3/21/2025 at 1:10 PM, he was unable to provide evidence that the facility's sprinkler system received proper inspection and testing, as required.	K353		