STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415045	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overlook Nursing and Rehabilitation Center	14 Rock Avenue Pascoag, RI 02859

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review, staff, resident, and resident representative interview, it has been determined that the facility failed to inform the resident and/or resident's 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, a medication prescribed to treat high blood pressure for 1 of 1 resident reviewed for the use of amlodipine, Resident ID #84. Findings are as follows: Review of the manufacturer's insert for amlodipine last revised in May of 2011, revealed the following possible side effects: - Headache - Swelling of the legs or ankles - Tiredness, extreme sleepiness - Stomach pain, nausea - Dizziness - Arrhythmia (irregular heartbeat) - Heart palpitations (very fast heartbeat) Additional review of the insert revealed that there is a potential risk of having a heart attack when first taking amlodipine. Record review revealed the resident was admitted to the facility in April of 2025 with a diagnosis including, but not limited to, hypertension (high blood pressure). Record review revealed the following progress notes: - 4/18/2025 at 12:17 PM, authored by the resident's Physician, revealed that the resident was started on amlodipine 5 milligrams (mg) once daily for blood pressure control. (continued on next page)

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.

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 4/18/2025 at 1:40 PM, authored by Licensed Practical Nurse, Staff A, revealed that the resident's Physician reviewed his/her blood pressures and gave a new order for amlodipine 5 mg once daily. Additionally, the above-mentioned notes failed to indicate that the resident, and/or his/her representative, was informed, in advance, of the addition of the amlodipine, the risks and benefits associated with the amlodipine, or the treatment alternatives prior to prescribing and administering the medication. Review of a physician's order with a start date of 4/18/2025 and a disocontinue date of 4/28/2025 revealed to administer amlodipine 5 mg daily. Review of the April 2025 Medication Administration Record (MAR) revealed that the resident was administered amlodipine 5 mg daily from 4/19 through 4/28. Review of a progress note dated 4/26/2025 at 9:42 PM revealed that the resident's family member, who is listed as his/her emergency contact, expressed concerns to the staff that the resident is dizzy and requested to know what medication the resident was receiving. Additionally, it revealed that the resident's family member was unaware of the addition of the amlodipine and the family member would contact the resident's physician. During a surveyor interview on 4/30/2025 at 12:59 PM with the resident and his/her representative, they revealed that neither of them were informed of the addition of the amlodipine to the resident's treatment plan. During a surveyor interview on 5/1/2025 at 11:18 AM with Staff A, she revealed that she did not notify the resident or his/her representative regarding the amlodipine and indicated that she should have. During a surveyor interview on 5/1/2025 at 4:33 PM with the Director of Nursing Services, she revealed that she would have expected the nurse to discuss the addition of the amlodipine to the resident's treatment plan with the resident and/or resident's representative prior to initiating treatment.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and staff interview, it has been determined that the facility failed to ensure that a resident with an injury of unknown origin was thoroughly investigated for 2 of 2 residents reviewed for skin tears, Resident ID #s 19 and 27. Findings are as follows: Review of a facility policy titled, Abuse prohibition states in part, .Injuries of unknown origin .the source of the injury was not observed or the source cannot be explained by the resident .Investigations .obtain statements from witnesses, notify the appropriate administrative personnel so that a comprehensive internal facility investigation can be carried out . 1. Record review revealed that Resident ID #19 was readmitted to the facility in July of 2024 with a diagnosis including, but not limited to, Alzheimer's Disease. Review of a progress note dated 4/26/2025 at 1:04 PM revealed that the resident presented with two new skin tears to his/her left upper extremity and s/he was unable to explain the origin of the skin tears. Further record review failed to reveal evidence that an investigation had been conducted to determine the origin of the two skin tears. During a surveyor interview on 5/1/2025 at 4:21 PM with the Director of Nursing Services (DNS), she acknowledged that the resident sustained an injury of unknown origin and was unable to provide evidence that an investigation was initiated and revealed that one should have been conducted. 2. Record review revealed that Resident ID #27 was readmitted to the facility in December of 2024 with a diagnosis including, but not limited to, chronic kidney disease. Review of a progress note dated 4/28/2025 revealed that the resident sustained a 1 centimeter skin tear to his/her left knee and the area was cleansed and two steri strips were applied. Additionally, the note failed to indicate the origin of the skin tear. Further record review failed to reveal evidence that an investigation had been conducted to determine the origin of the resident's skin tear to his/her left knee. During a surveyor interview on 5/5/2025 at 9:09 AM with Licensed Practical Nurse, Staff A, she acknowledged the progress note on 4/28/2025 did not contain an origin for the resident's skin tear. During a surveyor interview on 5/5/2025 at 2:37 PM with the DNS, she was unable to provide evidence that an investigation had been conducted to determine the origin of the resident's skin tear.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and staff interview, it has been determined that the facility failed to ensure that services provided meet professional standards of quality and practices relative to 1 of 2 residents reviewed for Abnormal Involuntary Movement Scale (AIMS) Assessments, Resident ID #23, and 1 of 1 resident reviewed that receives insulin without blood sugar monitoring in place, Resident ID #48. 1. Record review revealed Resident ID #23 was readmitted to the facility in August of 2022 with diagnoses including, but not limited to, anxiety, bipolar disorder, post-traumatic stress disorder (PTSD), and panic disorder. Review of the resident's care plan revealed a focus area dated 6/1/2022 for psychotropic medication (a medication that affects behavior, mood, thoughts, or perception) use and to complete an AIMS Assessment as directed. Review of a physician's order dated 5/17/2024 revealed to complete an AIMS Assessment on the 13th of every March, June, September, and December. Record review revealed the last AIMS Assessment for the resident was completed on 8/12/2024. Additionally, record review failed to reveal evidence that an AIMS Assessment was completed on 9/13/2024, 12/13/2024, or 3/13/2025, as ordered. During a surveyor interview on 5/6/2025 at 11:29 AM with the resident's Nurse Practitioner, she revealed that she would expect staff to complete the AIMS Assessments as ordered. During a surveyor interview on 5/6/2025 at 12:27 PM with the Director of Nursing Services (DNS), she acknowledged that an AIMS Assessment had not been completed since 8/12/2024 and would expect the assessments to be completed as ordered. 2. Record review revealed Resident ID #48 was readmitted to the facility in November of 2024 with a diagnosis including, but not limited to, diabetes mellitus due to an underlying condition with hyperglycemia (high blood sugar). Review of the resident's care plan revealed a focus area dated 2/18/2025 indicating that s/he is at risk for potential complications related to diabetes and potential adverse effects of receiving insulin. Review of a physician's order dated 1/27/2025 revealed to administer Semglee (insulin glargine-yfgn) 5 units subcutaneously (under the skin) once daily. Review of a progress note dated 11/5/2024 at 2:06 PM revealed that the resident's hemoglobin A1C (a blood test that measures a person's average blood sugar levels over the past 3 months and provides insight in diagnosing and managing diabetes) was to be repeated in 3 months. Record review failed to reveal evidence that the resident's hemoglobin A1C had been drawn following the above-mentioned progress note. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress notes dated 5/5/2025 at 11:50 AM and 12:44 PM, authored by the DNS, revealed that the resident had his/her hemoglobin A1C drawn on 11/1/2024 and his/her provider ordered a follow up hemoglobin A1C to be completed in 3 months. Additionally, new orders for labs were obtained and to be completed on 5/12/2025. Record review revealed that a physician's order for a hemoglobin A1C test was entered for 5/12/2025, after it was brought to the facility's attention by the surveyor. During a surveyor interview on 5/5/2025 at 11:37 AM with the DNS, she acknowledged that the last hemoglobin A1C completed for the resident was in November of 2024 and was unable to provide evidence that the resident's repeat hemoglobin A1C had been completed. Cross reference F 842

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, and resident interview, it has been determined that the facility failed to ensure that services provided by the facility meet professional standards of quality relative to following physician's orders for 1 of 2 residents reviewed for orthostatic blood pressures (a form of low blood pressure that happens when standing after sitting or lying down that may cause dizziness, lightheadedness, and fainting), Resident ID #23, and for 1 of 2 residents reviewed for physician referrals for appointments, Resident ID #52. Findings are as follows: According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, The physician is responsible for directing medical treatment, Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients. 1. According to [NAME] JJ. Antipsychotic pharmacotherapy and orthostatic hypotension: identification and management. CNS Drugs. 2011 Aug;25(8):659-71, states that, .Orthostatic hypotension is a common adverse effect of antipsychotics .monitoring for changes in postural blood pressure is important . Record review revealed Resident ID #23 was readmitted to the facility in August of 2022 with Parkinson's disease with dyskinesia (involuntary, uncontrolled movements), dizziness and giddiness, bipolar disorder, and a history of falling. Review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 15 out of 15, indicating intact cognition. Review of the resident's care plan revealed that s/he is at risk for falls related to dizziness, potential medication side effects, effects of Parkinson's Disease, and the need for assistance with ambulation and transfers with interventions that includes to report changes in vital signs and complaints of dizziness. Additional review of the resident's care plan revealed a focus area dated 6/1/2022 for psychotropic medications (medication that affects behavior, mood, thoughts, or perception). Record review revealed the following physician's orders: - 5/17/2024 Orthostatic vital signs every 3 months - 8/22/2024 Seroquel (an antipsychotic medication) 25 milligrams (mg) give 25 mg at bedtime - 10/3/2024 Seroquel 25 mg give 12.5 mg once daily Review of the progress notes revealed the following: - 12/15/2024: The resident had an unwitnessed fall in the bathroom - 1/9/2025: The resident complained of dizziness after ambulating from bathroom (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 3/3/2025: The resident sustained a fall from his/her chair - 3/10/2025: The resident stated that s/he was too dizzy to walk to the bathroom Record review revealed that the resident had a change in orthostatic blood pressures as evidenced by the following quarterly fall assessments: - 12/14/2024 No noted drop in blood pressure between lying and standing - 3/14/2025 A drop of more than 20 mm/hg (millimeter of mercury; units of pressure for measuring blood pressure) Record review failed to reveal evidence that the provider was made aware of the resident's change in orthostatic blood pressures. During a surveyor interview on 5/1/2025 at 11:08 AM with the resident, s/he was asked if s/he gets dizzy when attempting to stand from a sitting or lying position and s/he replied, Oh, yeah. During a surveyor interview on 5/6/2025 at 11:04 AM with Licensed Practical Nurse, Staff A, she revealed that the resident has a history of falls and dizziness. She further revealed that if the resident had a change in orthostatic blood pressures noted between the quarterly fall assessments, she would document it and notify the provider. During a surveyor interview on 5/6/2025 at 11:29 AM with the resident's Nurse Practitioner, she revealed that she would expect to be notified of the change in orthostatic blood pressures and she would then review his/her blood pressures, medications, and fluid intake to ensure it is adequate, and reassess the resident. During a surveyor interview on 5/6/2025 at 12:27 PM with the Director of Nursing Services (DNS), she revealed that she would expect the provider to be notified if the resident had a change in orthostatic blood pressures and was unable to provide evidence that the provider was made aware. 2. Record review revealed Resident ID #52, was admitted to the facility in March of 2023 with diagnoses including, but not limited to, spinal stenosis (a condition in which your spinal canal narrows, causing back pain and other nerve-related problems) and neurogenic bladder dysfunction (a urinary bladder condition caused by damage to the nerves that control bladder function). Record review revealed the following physician's orders: - Urology consult for possible suprapubic tube (SP tube, a medical device that drains urine from the bladder through a small incision in the abdomen) insertion due to history of difficulty maintaining indwelling catheter initiated on 3/19/2025 - MRI (a medical imaging technique) of the spine without contrast related to chronic back pain, initiated on 3/19/2025 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note dated 3/19/2025, revealed the resident was seen by his/her physician and expressed interest in having an SP tube placed. Additionally, the note indicates the Physician educated the resident on risks and benefits of the SP tube and further indicated an appointment should be scheduled. Review of a progress note dated 4/17/2025 revealed a continued need to schedule an MRI for chronic back pain. Record review failed to reveal evidence of an appointment with urology for the placement of an SP catheter or an MRI for chronic back pain had been scheduled for Resident ID #52. During a surveyor interview on 5/1/2025 at 2:36 PM with the facility's Appointment Scheduler, Staff C, she revealed that she was unaware of the resident's need for a urology appointment or an MRI until it was brought to her attention by the surveyor. During a surveyor interview on 5/1/2025 at 2:46 PM with Licensed Practical Nurse, Staff D, she revealed that an appointment for urology or an MRI had not been made. Additionally, she revealed that if the resident refused to go to an appointment, then a note would be put in his/her medical record. During a surveyor interview on 5/5/2025 at 11:21 AM with the DNS, she was unable to provide evidence that appointments for a urology consult or an MRI had been scheduled as ordered.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to ensure that a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 1 resident observed for wound care, Resident ID #52. Findings are as follows: Record review revealed the resident was admitted to the facility in March of 2023 with diagnoses including, but not limited to, spinal stenosis (a condition in which your spinal canal narrows, causing back pain and other nerve-related problems) and stage 4 pressure ulcer (the most severe pressure wound that may impact muscle, tendons, ligaments, and bone). Review of a progress note dated 4/28/2025 revealed the resident has the following wounds: - Stage 4 pressure ulcer to his/her coccyx (tailbone) measuring 3.5 centimeters (cm) X 2.5 cm X 1 cm. - Stage 4 pressure ulcer to his/her right gluteal fold (visible crease that separates the gluteal region from the upper thigh) measuring 3.3 cm X 2 cm X 2 cm. Record review revealed the following physician's orders for wound care: - Coccyx stage 4 pressure ulcer, vashe soak (wound cleanser) for 10 minutes, apply collagen with silver and calcium alginate (absorbent wound treatment) to wound bed, pack with kerlix (highly absorbent wound dressing) and cover with super absorbent dressing daily. - Right gluteal fold stage 4 pressure ulcer, vashe soak for 10 minutes, apply collagen powder to the wound bed then pack with calcium alginate and cover with silicone super absorbent dressing daily. During a surveyor observation of wound care on 5/1/2025 at 10:24 AM with Registered Nurse (RN), Staff E, she applied the collagen powder on top of the calcium alginate and packed it into the resident's coccyx wound with her gloved fingers. She then was observed to pack a ball of kerlix into the wound with her gloved fingers and not an applicator. Directly following the application to the coccyx wound, Staff E was observed to apply collagen powder on top of the calcium alginate and then pack into the wound to the right gluteal fold with her fingers and not an applicator. Staff E did not change her gloves between packing the coccyx wound and the gluteal fold wound. During a surveyor interview on 5/1/2025 at 10:50 AM with, Staff E, she acknowledged that she did not utilize an applicator to pack the wounds. Additionally, she acknowledged she did not change her gloves after applying the coccyx wound dressing and before applying the right gluteal fold wound dressing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 5/1/2025 at 11:02 AM with the Director of Nursing Services (DNS), she acknowledged that Staff E should have utilized an applicator to pack the wound and should have changed her gloves between wound treatments. Additionally, the DNS was unable to provide evidence that the facility provided wound care consistent with professional standards of practice, to promote healing, and prevent infection for Resident ID #52.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, it has been determined that the facility failed to ensure that a resident's environment remains as free of accident hazards as possible for 1 of 1 resident reviewed who sustained a burn, Resident ID #27. Findings are as follows: Review of an article published by the Journal of Food Science, dated July 11, 2019, titled A Review of Hot Beverage Temperatures-Satisfying Consumer Preference and Safety states in part, .An appropriate range for service temperatures is 130 to 160 °Fahrenheit (F) .This recommendation balances a range of consumer preferences and safety . Record review revealed the resident was admitted to the facility in December of 2024 with diagnoses including, but not limited to, chronic kidney disease, dependence on renal dialysis, and diabetes. Record review of a Quarterly Minimum Data Set assessment dated [DATE], revealed a Brief Interview of Mental Status score of 14 out of 15, indicating intact cognitive function. Record review a progress note dated 3/26/2025 revealed that at approximately 7:00 PM, the resident spilled hot chocolate on him/herself. His/her skin was assessed at approximately 8:00 PM and revealed redness with an intact blister on the outside of the left thigh. Skin prep and a border gauze was applied. Record review of a progress notes dated 3/31/2025 at 12:08 PM states in part, .left thigh with a new area measuring 7.7 x 13.5 x 0.1 [centimeters] 30% dermis [middle layer of skin], 70% epithelial [outer layer of skin] no drainage or signs of infection. The resident stated [s/he] spilled hot cocoa on [him/herself] during a meal [s/he] was having with a friend who was visiting over the weekend . Record review of a document titled, Integrated Wound Care dated 4/14/2025, revealed the resident had a left thigh burn measuring 7 by 12 centimeters (cm) and 0.1 cm deep noted with 30% scabbing. Additionally, the burn was noted as a second-degree burn (damage to the outer layer of skin and some of the underlying layer of skin). During a surveyor interview with the resident on 5/1/2025 at 8:37 AM, s/he revealed that on the evening of 3/26/2025, a Nursing Assistant made him/her a cup of hot chocolate using a Keurig brand coffee maker located on the 1st floor kitchenette. Resident ID #27 indicated s/he had put the cup of hot chocolate on the edge of table, and it spilled onto his/her leg. S/he further revealed that the spilled hot chocolate on his/her thigh was very painful. During a surveyor observation of the 1st floor kitchenette on at 5/1/2025 at 10:27 AM, revealed Nursing Assistant (NA) Staff F, warming a plated breakfast meal for a resident using the facility provided microwave. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a surveyor interview with Staff F immediately following the observation, she revealed that she had been a NA at the facility for approximately 6 months and during this time she had not been provided education on safe temperatures when reheating meals for residents or serving hot beverages. She further revealed she was not aware of what temperatures are too hot and may be harmful. During a surveyor interview on 5/5/2025 at 9:17 AM with the Staff Educator, she revealed that education of reheating or serving food and beverages was not provided to any staff member. During a surveyor observation on 5/5/2025 at 1:47 PM in the presence of Licensed Practical Nurse, Staff A, an 8-ounce (oz) cup of hot water was obtained from the available Keurig brand coffee maker located in the first-floor kitchenette. The water temperature in the 8 oz cup was 180.3 F. Additionally, Staff A indicated the water was too hot to touch and acknowledged it would cause injury to skin. During a surveyor interview on 5/5/2025 at 2:37 PM with the Administrator in the presence of the Director of Nursing Services, she acknowledged that Resident ID #27 had sustained a second degree burn from hot chocolate provided to him/her by the facility. She further indicated that she was aware that education had not been provided to reduce the risk of accidents associated with hot liquids.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on surveyor observation, record review, and staff interview it has been determined that the facility failed to provide appropriate treatment and services for 1 of 3 residents reviewed with a foley catheter (a hollow, partially flexible tube that collects urine from the bladder and leads to a drainage bag), Resident ID #35, and for 1 of 2 residents with a suprapubic catheter (SP tube, a medical device that drains urine from the bladder through a small incision in the abdomen) Resident ID #45. Additionally, the facility failed to assess for the removal of a urinary catheter for 1 of 1 resident reviewed requiring a trial void, Resident ID #39. Findings are as follows: Review of a facility policy titled, Foley Catheters dated 1/16/2024 states in part, It is the policy of this facility to ensure that the resident (s) with a foley catheter (or SP tube) have the proper documentation in place to support the usage and proper care of the foley catheter .A resident with a foley catheter (or SP tube) must have a physician order in place for the foley catheter. The order must include the size of the catheter and the balloon .The order must also include the diagnosis to support the reason for the foley catheter . 1. Record review revealed that Resident ID #35 was admitted to the facility in September of 2024 with a diagnosis including, but not limited to, obstructive uropathy (a blockage that prevents urine from flowing naturally through the urinary system). Review of a care plan dated 1/22/2025 revealed that Resident ID #35 has urinary retention with an intervention including, but not limited to, foley catheter care every shift. During a surveyor observation on 5/1/2025 at 9:29 AM of Resident ID #35 revealed a foley catheter hanging from the left side of his/her bed. Record review failed to reveal a physician's order for the foley catheter including the size of the catheter, the balloon size, or the diagnosis to support the use, per the facility policy. During a surveyor interview on 5/1/2025 at 1:50 PM with Licensed Practical Nurse (LPN), Staff D, she acknowledged that there was not an order in place for Resident ID #35's foley catheter. During a surveyor interview on 5/1/2025 at 1:56 PM with the Director of Nursing Services (DNS), she acknowledged that there was not an order in place for the foley catheter including the catheter size and balloon size, and/or a diagnosis for its use, per the facility policy. 2. Record review revealed that Resident ID #45 was readmitted to the facility in February of 2024 with diagnoses including, but not limited to, urinary tract infection and neuromuscular dysfunction of the bladder (lack of bladder control due to brain, spinal cord or nerve problems). Review of a care plan dated 3/15/2021 revealed that Resident ID #45 utilizes an SP catheter for urinary retention and is at high risk for recurrent urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review failed to reveal an order for the SP catheter including the size of the catheter, the balloon size, or the diagnosis to support its use, per the facility policy. During a surveyor interview on 5/1/2025 at 4:20 PM with the DNS she acknowledged that there is not an order for use of the SP catheter including the catheter and balloon size and a diagnosis for its use, per the facility policy. 3. Record review revealed that Resident ID #39 was admitted to the facility in August of 2024 with diagnoses including, but not limited to, obstructive uropathy and urinary retention. Record review revealed a physician order dated 11/21/2024 for a foley catheter. Review of a progress note dated 1/14/2025 revealed that Resident ID #39 saw a urologist who provided a recommendation to have a trial void in one week. Record review revealed a physician's order with a start date of 1/22/2025 to remove the foley catheter for a trial void and if s/he does not void in 8 hours to reinsert the foley catheter. Record review failed to reveal evidence that a trial void was attempted or failed. During a surveyor interview on 5/5/2025 at 2:18 PM with the DNS, she was unable to provide evidence that a trial void was attempted for Resident ID #39 as ordered.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide respiratory care consistent with professional standards of practice for 1 of 1 resident reviewed for oxygen use, Resident ID #7. Findings are as follows: According to Lippincott Nursing Procedure Ninth Edition 2023, page 621, states in part, .Verify the practitioner's order for the oxygen therapy, because oxygen is considered a medication or therapy and should be prescribed . Record review revealed the resident was readmitted to the facility in May of 2024 with diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD) and acute and chronic respiratory failure with hypercapnia (a condition where there are abnormally high levels of carbon dioxide in the blood that could be caused by conditions like COPD). Review of the care plan revealed that the resident utilizes oxygen at 2 liters per minute (LPM). Review of a physician's order dated 6/10/2024 revealed an order for oxygen 2 LPM every shift. Review of the resident's carbon dioxide levels revealed that the s/he had increasingly elevated levels which can be attributed to COPD, as well as, individuals that utilize supplemental oxygen, as evidenced by the following: - 12/12/2024 Carbon dioxide level (normal range 19-32): 31 - 2/19/2025 Carbon dioxide level: 33 - 4/4/2025 Carbon dioxide level: 35 Surveyor observations revealed the resident was not receiving the 2 liters of oxygen as ordered on the following dates and times: - 4/30/2025 at 11:54 AM, noted at approximately 3.5 LPM - 5/1/2025 at 9:22 AM, 2:33 PM, and 2:39 PM, noted at approximately 3.5 LPM During a surveyor interview immediately following the above observation at 2:39 PM with Registered Nurse, Staff G, she acknowledged that the resident was not receiving the 2 liters of oxygen as ordered. During a surveyor interview on 5/1/2025 at 4:30 PM with the Director of Nursing Services, she indicated that she would have expected the resident to receive oxygen at 2 LPM, as ordered. Cross reference F 842

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. Based on record review and staff interview, it has 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 a urinary tract infection (UTI), Resident ID #45. Findings are as follows: Record review revealed the resident was readmitted to the facility in February of 2024 with a diagnosis including, but not limited to, UTI. Record review revealed the following progress notes: -3/12/2025 at 12:43 PM: The resident was seen by the provider and is to start Bactrim (an antibiotic) 800 milligrams (mg) twice daily for 7 days (to equal 14 total doses) -3/13/2025 at 10:48 PM: The resident continues Bactrim for a UTI Review of a physician's order dated 3/12/2025 revealed Bactrim DS 800-160 mg administer 1 tablet twice daily for 7 days (to equal 14 total doses). Review of the March 2025 Medication Administration Record revealed that the resident received a total of 17 doses of Bactrim from 3/12 through 3/20, thus receiving an additional 3 doses more than what the provider had prescribed. During a surveyor interview on 5/5/2025 at 11:37 AM with the Director of Nursing Services, she revealed that she would have expected the resident to have received only 14 doses of Bactrim, as prescribed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that food is stored and distributed in accordance with professional standards for food service safety, relative to the main kitchen and 2 of 2 kitchenettes observed. Findings are as follows: Record review of Rhode Island Food Code, 2022 Edition, Section 3-501.17 states in part, .READY -TO-EAT-TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and help in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the premises, sold, or discarded when held at a temperature of 5 degrees Celsius or 41 degrees Fahrenheit or less for a maximum of 7 days. The day of preparation shall be counted as Day 1 . Record review of the Rhode Island Food Code 2022 edition, section 4-602.11 states in part, .(C) NON_ FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris . 1) During the initial tour of the kitchen in the presence of the Food Service Director (FSD), on 4/30/2025 at 9:55 AM, the following was observed in the main kitchen: - a bag containing approximately one dozen pieces of fried chicken without a label or discard date - a bag containing approximately 15-20 pieces of chicken patties in the freezer without a label or discard date - package containing 5 frozen hamburger patties in the freezer without a label or discard date - 3 bags of 2-3 pancakes wrapped in saran wrap in the freezer, without a label or discard date - a large zip lock style bag in the freezer, containing approximately 3-4 pounds of shaved beef without a label or discard date, with ice formed on the inside of the bag. During a surveyor interview on 4/30/2025 at 10:04 AM with the Food Service Director (FSD), he acknowledged the above-mentioned items did not have labels and or discard dates per the regulations. 2) Record review of the facility policy titled Use and Storage of Food Brought in by Visitors revised on 4/18/2024, states in part .food for residents .is to be labeled with the resident's name and date .discard those perishable items that appear unsafe or are older than 3 days . During a surveyor observation on 5/1/2025 at 10:02 AM, of the 1st floor kitchenette, in the presence of the FSD, the following was observed: - a container in the refrigerator labeled with only a resident's name, without a discard date - a brown box in the freezer labeled with only a resident's name, without a discard date (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a subsequent interview with the FSD, he indicated that he would expect the above items to be labeled, dated or discarded date per the facility policy. 3) During a surveyor observation on 5/1/2025 at 10:13 AM, of the 2nd floor kitchenette, in the presence of the FSD, the following was observed: - a large Ziplock style bag containing what appeared to be tacos without a label or discard date - the refrigerator contained a clear plastic container containing an unidentified food substance that was thick, dark orange in color with a pasty texture without a label or discard date - the oven was observed with residual burnt matter on the inside, dark in color scattered on the bottom During a surveyor interview on 5/1/2025 at 10:16 AM with the FSD, he acknowledged the above observations. Additionally, he was unable to provide a cleaning schedule for the oven. During a surveyor interview on 5/1/2025 at 11:06 AM with the Administrator, she revealed that it was her expectation that the above-mentioned items would have been labeled, dated or discarded as indicated per the regulations and per the facility policy.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and staff interview, it has been determined that the facility failed to accurately maintain the resident's medical record in accordance with accepted professional standards and practices for 1 of 1 resident reviewed for oxygen use, Resident ID #7, and 1 of 2 residents reviewed for Abnormal Involuntary Movement Scale (AIMS) Assessments, Resident ID #23. Findings are as follows: 1. Record review revealed Resident ID #7 was readmitted to the facility in May of 2024 with a diagnosis including, but not limited to, chronic obstructive pulmonary disease (COPD). Review of the care plan revealed that the resident utilizes oxygen at 2 liters per minute (LPM). Review of a physician's order dated 6/10/2024 revealed oxygen at 2 LPM every shift. Surveyor observations revealed the resident was not receiving the 2 liters of oxygen as ordered on the following dates and times: - 4/30/2025 at 11:54 AM, noted at approximately 3.5 LPM - 5/1/2025 at 9:22 AM, 2:33 PM, and 2:39 PM, noted at approximately 3.5 LPM Review of the April and May 2025 Medication Administration Records (MARs) revealed that the resident was documented as receiving oxygen at 2 LPM on the above-mentioned dates and times, although the resident was observed by the surveyor receiving approximately 3.5 liters of oxygen. Additional review of the May 2025 MAR revealed that Registered Nurse, Staff G, documented the resident as receiving oxygen at 2 LPM on 5/1/2025 on the 7:00 AM to 3:00 PM shift. During a surveyor interview on 5/1/2025 at 2:39 PM with Staff G, she revealed that she noted that the resident was receiving oxygen at 3 LPM earlier that morning, and was unable to explain why she documented the resident as receiving oxygen at 2 LPM. 2. Record review revealed Resident ID #23 was readmitted to the facility in August of 2022 with diagnoses including, but not limited to, anxiety, bipolar disorder, post traumatic stress disorder (PTSD), and panic disorder. Review of the resident's care plan revealed a focus area dated 6/1/2022 for psychotropic medications (medications that affects behavior, mood, thoughts, or perception) use and to complete an AIMS Assessment as directed. Review of a physician's order dated 5/17/2024 revealed to complete an AIMS assessment on the 13th of every March, June, September, and December. Record review revealed that an AIMS Assessment was documented as completed on the following dates: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 9/13/2024 - 12/13/2024 - 3/13/2025 Further record review revealed the last AIMS Assessment was completed on 8/12/2024. Additionally, record review failed to reveal evidence that an AIMS Assessment was completed on 9/13/2024, 12/13/2024, or 3/13/2025, as documented. During a surveyor interview on 5/1/2025 at 4:30 PM with the Director of Nursing Services, she was unable to provide evidence that the facility maintained medical records that are accurate and would expect such. Cross reference F 695 and F 658

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 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 3 of 3 residents reviewed for antibiotic use, Resident ID #s 1, 12, and 343. Additionally, the facility failed to develop or maintain and Antibiotic Stewardship Team. Findings are as follows: 1. According to the Centers for Disease Control and Prevention (CDC) document titled, The Core Elements of Antibiotic Stewardship for Nursing Homes states in part, .Perform reviews on resident medical records for new antibiotic starts to determine whether the clinical assessment, prescription documentation and antibiotic selection were in accordance with facility antibiotic use policies and practices. When conducted over time, monitoring process measures can assess whether antibiotic prescribing policies are being followed by staff and clinicians .Requires prescriber's to document a dose, duration, and indication for all antibiotic prescriptions . Review of a facility policy titled, Antibiotic Stewardship states in part, .The antibiotic stewardship program is directed toward the correct use of antibiotic- the five D's -right diagnosis, the right medication, the right dose, the right duration, and the right deceleration . 1a. Record review revealed that Resident ID #1 was admitted to the facility in December of 2024 with a diagnosis including, but not limited to, acute bronchiolitis due to respiratory syncytial virus (an acute viral infection of the lower respiratory tract). Record review revealed a physician's order dated 4/29/2025 for ciprofloxacin suspension (antibiotic) 500 milligram (mg) per 5 milliliters (ml), administer 5 ml twice a day. Review of the physician's order for ciprofloxacin suspension, failed to reveal evidence of the indication of use for the antibiotic per the CDC and the facility policy. 1b. Record review revealed that Resident ID #12 was readmitted to the facility in April of 2025 with a diagnosis including, but not limited to, aftercare following surgical amputation. Record review revealed a physician's order dated 4/29/2025 for sulfamethoxazole-trimethoprim (antibiotic) 800-160 mg, administer 1 tablet twice a day. Review of the physician's order for sulfamethoxazole-trimethoprim, failed to reveal evidence of the indication of use for the antibiotic per the CDC and the facility policy. 1c. Record review revealed that Resident ID #343 was readmitted to the facility in April of 2025 with a diagnosis including, but not limited to, pneumonia. Record review revealed a physician's order dated 4/29/2025 for amoxicillin-pot clavulanate (antibiotic) 875-125 mg, administer 1 tablet twice a day. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician's order for amoxicillin-pot clavulanate, failed to reveal evidence of the indication of use for the antibiotic per the CDC and the facility policy. During surveyor interviews on 5/1/2025 at 9:25 AM and 11:40 AM, with the Director of Nursing Services (DNS), she revealed that all antibiotics should have the indication for use in the physician's orders. Additionally, she acknowledged the above-mentioned orders for Resident ID #s 1, 12, and 343, failed to list an indication for the use of the antibiotics. Furthermore, the physician's orders were updated after it was brought to the facility's attention by the surveyor. 2. Further review of a facility policy titled, Antibiotic Stewardship states in part, .the Antibiotic Stewardship Team as outlined below, will meet on a regular scheduled basis. Minutes will be recorded and maintained for review. The efficacy of work of program will be analyzed at least annually and goals re-established each year based on the annual analysis . During a surveyor interview on 5/1/2025 at 9:20 AM, with the DNS, when asked about the antibiotic stewardship team and meeting minutes, the DNS revealed that the facility does not have an antibiotic stewardship team. Additionally, she acknowledged the policy states that the facility has an active antibiotic stewardship team and that they do not have one.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it has been determined that the facility failed to ensure the resident's medical record includes documentation that the resident either received the pneumococcal vaccination or did not receive the vaccination due to medical contraindications or refusal, for 3 of 5 residents reviewed, Resident ID #s 21, 32, and 37. Findings are follows: According to the Centers for Disease Control and Prevention (CDC), pneumococcal vaccination for all adults 19 through [AGE] years old who have certain chronic medical conditions or 65 years or older who have only received PPSV23 [type of pneumococcal conjugate vaccination], the PCV15 [type of pneumococcal conjugate vaccine] or PCV20 [type of pneumococcal conjugate vaccine] dose should be administered at least one year after the most recent PPSV23 vaccination. For adults 19 through [AGE] years old who have certain chronic medical indications who have only received PCV13 [type of pneumococcal conjugate vaccine], give 1 dose of the PCV20 at least 1 year after PCV13 or give 1 dose of PPSV23 at least 8 weeks after PCV13. For adults 65 years or older who have only received PCV13, give PPSV23 or PCV20 as previously recommended. Together, with the patient, vaccine providers may choose to administer PCV20 or PCV21 to adults greater than or equal to [AGE] years old who have already received PCV13 (but not PCV15, PCV20, or PCV21) at any age and PPSV23 at or after the age of [AGE] years old. 1. Record review for Resident ID #21 revealed the resident was admitted to the facility in November of 2018. Record review of the resident's immunization records revealed that the resident completed his/her initial series including PCV13 and PPSV23. Record review failed to reveal evidence that resident was offered, received, or declined the PCV20 or PCV21. 2. Record review for Resident ID #32 revealed the resident was admitted to the facility in April of 2018. Record review revealed that the resident consented to the Pneumococcal vaccination in May of 2023. Record review of the resident's immunization records failed to reveal evidence that the PPSV23, or PCV20 was received or declined. 3. Record review for Resident ID #37 revealed the resident was admitted to the facility in March of 2019. Record review of the resident's immunization records revealed that the resident completed his/her initial series including PCV13 and PPSV23. Record review failed to reveal evidence that the resident was offered, received, or declined the PCV20 or PCV21. During a surveyor interview on 5/1/2025 at 11:31 AM, with the Director of Nursing Services, she revealed that she contacted the Medical Director and those who have completed the pneumococcal vaccination series should be offered the PCV20 or PCV21. Additionally, she was unable to provide evidence that Resident ID #s 21, 32, and 37's medical records included documentation that indicates, at a minimum, if the residents either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal, until brought to the facility's attention by the surveyor.