STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415096	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Home of Rhode Island	111 South Angell Street Providence, RI 02906

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident and staff interview, it has been determined that the facility failed to ensure that self-administration of medications was clinically appropriate for 1 of 1 resident observed with an insulin pump (a computerized device that delivers a continuous dose of insulin to people with diabetes to manage blood sugar levels), Resident ID #9.Findings are as follows:Record review of a facility policy and procedure titled, Self-Administration of Medication by Resident, last revised on 10/16/2025, states in part, Residents may self-administer medications with a physician's orders.The resident will be instructed on the use and reason for the medication, reading of the label, the dosing and schedule. The resident shall then be evaluated on these tasks using the Assessment of Resident's Ability to Self-Medicate Form. The resident will be asked to read the label and indicate what time the medication should be administered. The resident's ability to perform this task will be evaluated by assessing the resident's cognitive, physical and visual ability to self-medicate . The Assessment of Resident's Ability to Self-Medicate.will be completed prior to him/her self-administration medication. Physician order must be obtained and documented in PCC [Point Click Care - an electronic medical record software].Record review revealed the resident was admitted to the facility in October of 2025 with a diagnosis including, but not limited to, type 2 diabetes mellitus.Record review of a quarterly Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 15, indicating s/he is cognitively intact.Record review revealed a physician's order dated 10/17/2025 to monitor the insulin pump site for infection, battery life, insulin chamber levels, and kinks in the tubing every shift. Further review of the physician's orders failed to reveal evidence of an order specifying the necessity of the insulin pump, the type of pump being used, or the type of insulin being administered through the pump.During a surveyor interview on 11/25/2025 at approximately 11:20 AM with Resident ID #9, s/he revealed that s/he has an insulin pump in place and that s/he manages it independently.Record review failed to reveal evidence that the resident has received a self-administration assessment for the insulin pump. During a surveyor interview on 11/25/2025 at 12:42 PM with the Director of Nursing Services, he revealed that the insulin pump is managed by the resident. He acknowledged that the facility failed to complete an assessment of the resident's ability to self-administer medications.Refer to F 658, F 726 and F 842

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on surveyor observation, record review, and staff interview, it has been determined the facility failed to protect identifying information about complainants or residents that were identified in the survey results binder. Findings are as follows:During a surveyor observation on 11/25/2025 at approximately 11:00 AM, of the main lobby, a black binder with a title of State Survey Results was stored on the reception area countertop, facing the public as they entered the facility.Record review of the binder revealed the following:2023 annual federal recertification survey results2024 annual federal recertification survey resultsAdditional record review revealed resident rosters (a list provided to a facility that corresponds to a number identifier use in a survey to protect privacy) included in the survey binder. During a surveyor interview on 11/26/2025 at 10:30 AM, with the Administrator, she acknowledged that the residents' names along with their corresponding number identifier were in the binder and available for the general public to view.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, relative to 1 of 1 resident reviewed for an insulin pump (a computerized device that delivers a continuous dose of insulin to people with diabetes to manage blood sugar levels) utilization, Resident ID #9, 1 of 2 residents reviewed with parameters for medication administration, Resident ID #22, 1 of 1 resident reviewed related to anticonvulsant symptom monitoring, Resident ID #4, and 1 of 2 residents reviewed related to antipsychotic symptom monitoring, Resident ID #16.Findings are as follows:According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states in part, The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe that the orders are in error or would harm the clients .1. Record review revealed Resident ID #9 was admitted to the facility in October of 2025 with a diagnosis including, but not limited to, type 2 diabetes mellitus.Record review of the care plan revised, 11/21/2025 revealed in part, .has insulin pump. Staff to.ensure proper insulin administration. If necessary, assist.to load pump.During a surveyor interview on 11/25/2025 at approximately 11:20 AM with Resident ID #9, s/he revealed that s/he has an insulin pump in place and that s/he manages it independently.Record review failed to reveal evidence of an order specifying the necessity of the insulin pump, the type of pump being used, or the type of insulin being administered through the pump.During a surveyor interview on 11/25/2025 at 12:42 PM with the Director of Nursing Services (DNS), he revealed that the insulin pump is managed by the resident and failed to reveal evidence that the facility identified the necessity of the insulin pump, the type of pump being used, or the type of insulin being administered through the pump.Refer to F 554, F 726 and F 8422. Record review revealed Resident ID #22 has a physician's order with a start date of 10/24/2025 for losartan potassium (a medication prescribed to treat high blood pressure), oral tablet 50 milligrams (mg), by mouth, every morning for hypertension. Additional review revealed instructions with a parameter to hold the losartan potassium if the resident's systolic blood pressure (SBP - the top number in a blood pressure reading that measures the force of blood against your artery walls when your heart beats and pumps blood) is less than 110 mmHg (millimeters of mercury).During a surveyor observation on 11/25/2025 at 8:16 AM, during the medication pass, Certified Medication Technician, Staff A, failed to obtain Resident ID #22's SBP to ensure that it is not less than 110 mmHg prior to administering the losartan, as ordered.Record review of Resident ID #22's vital sign record and Medication Administration Record/Treatment Administration Record (MAR/TAR) for November of 2025, failed to reveal evidence that his/her SBP was taken, 20 out of 24 opportunities.During a surveyor interview on 11/26/2025 at 11:58 AM with the DNS, he acknowledged Resident ID #22's SBP should be monitored and recorded prior to administering his/her losartan, per the physician's order.3. Record review revealed Resident ID #4 has a physician's order dated 4/6/2025 for Pregabalin (an anticonvulsant medication prescribed to treat seizures). Further record review revealed a physician's order dated 6/5/2025 to monitor Resident ID #4's blood pressure and heart rate changes every shift, related to anticonvulsant utilization.Record review of Resident ID #4's vital sign record and MAR/TAR for November of 2025, failed to reveal documentation that his/her blood pressure and heart rate were monitored every shift, as ordered.During a surveyor interview on 11/26/2025 at approximately 11:30 AM with the DNS, he was unable to provide evidence that the resident's blood pressure and heart rate were being monitored every shift.4. Record review revealed Resident ID #16 has a physician's order dated 2/18/2025 for clonazepam (a medication prescribed to treat panic disorders) 0. 5 mg in the morning, and 0.25 mg in the evening. Further record review revealed a physician's order dated 3/7/2025 to monitor blood pressure, heart rate changes, changes in behavior, rash, fever, or dizziness, every shift while on clonazepam. Record review of the vital sign record and MAR/TAR for November of 2025 failed to reveal evidence of a documented blood pressure or heart rate every shift.During a surveyor interview on 11/26/2025 at 11:12 AM with Registered Nurse, Staff B, he could not provide evidence that the blood pressure or heart rate were taken each shift, per the physician's order.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident and staff interview, it has been determined that the facility failed to ensure that licensed nurses have the specific competencies, and skill sets necessary to provide quality care and respond to each resident's individualized needs for 1 of 1 resident reviewed who uses an insulin pump (a computerized device that delivers a continuous and precise dose of insulin to people with diabetes to manage blood sugar levels), Resident ID #9.Findings are as follows:Review of the Annual Facility Assessment, last revised on 10/17/2024, revealed in part, .Staff Competencies.nurses are competent in. diabetes .[NAME] Home encourages and financially supports all educational activities and certifications. Support for education in all areas are cornerstone of the mission to provide quality care.Record review revealed the resident was admitted to the facility in October of 2025 with a diagnosis including, but not limited to, type 2 diabetes mellitus. Record review of the care plan revised, 11/21/2025, revealed in part, .has insulin pump. Staff to.ensure proper insulin administration. If necessary, assist.to load pump.Record review revealed a physician's order dated 10/17/2025 to monitor the insulin pump site for infection, battery life, insulin chamber levels, and kinks in the tubing every shift. Further review of the physician's orders failed to reveal evidence of an order specifying the necessity of the insulin pump, the type of pump being used, or the type of insulin being administered through the pump.Record review of the insulin pump user's manual obtained by the facility upon surveyor request on 11/25/2025 revealed, the resident was using a t: slim X2 Insulin Pump. Additionally, it revealed in part, .WARNINGS.DO NOT start to use t: slim X2 Insulin Pump before reading the User's Guide. Failure to follow the instructions can result in over delivery or under delivery of insulin. This can cause very low or very high blood glucose which could result in serious injury or death. DO Not start to use your t: slim X2 system before you have been appropriately trained on its use by a certified t: slim X2 system trainer.Record review of the nursing staff competencies for Registered Nurse (RN), Staff B, Staff C, Staff D, and Staff E, failed to reveal evidence of training on the use of the insulin pump. During a surveyor interview on 11/25/2025 at approximately 11:20 AM with the resident s/he revealed that s/he has an insulin pump in place and that s/he manages it independently.During a surveyor interview on 11/25/2025 at approximately 12:30 PM, with RNs, Staff D and E, they revealed that they have not received any training from the facility regarding the use of the insulin pump. Staff D indicated to the surveyor that she looked up online for information about the pump. During a surveyor interview on 11/25/2025 at 10:45 AM with DNS, he revealed that he screens all the residents prior to arrival to ensure the facility can take care of the residents. Additionally, he revealed that he has not received or provided the nursing staff with any training on the use of the insulin pump. Lastly, he acknowledged that if the facility nursing staff were to manage the insulin pump, it would be out of their competencies.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility policy for food brought in from an outside source failed to ensure safe and sanitary storage, handling, and consumption.Findings are as follows:Record review of a facility policy titled, Food Brought in From Outside the Facility Policy, dated 6/1/2021, states in part, [NAME] Home has no responsibility should any adverse reaction occur from food(s) when it has been brought into the facility from an outside source .The facility's policy failed to ensure the following requirements that are within regulations:-that staff assist the resident in accessing and consuming the food, if the resident is not able to do so independently-help visitors and family to understand safe food handling practices including, but not limited to, safe cooling and reheating processes, hot and cold holding temperatures, preventing cross contamination, and hand hygiene.During a surveyor interview on 11/26/2025 at approximately 11:30 AM with the Administrator, she acknowledged that the facility's policy related to food brought in from an outside source for residents failed address the facility's responsibilities in the safeguarding of food brought in from an outside source.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 ensure that resident records are complete and accurately documented, relative to blood sugar monitoring for 1 of 1 resident reviewed, Resident ID #9.Findings are as follows:Record review revealed the resident was admitted to the facility in October of 2025 with a diagnosis including, but not limited to, type 2 diabetes mellitus.Record review revealed a physician's order dated 10/18/2025 to monitor blood glucose prior to meals from Dexcom (a continuous glucose monitor prescribed for people with diabetes to track their glucose levels in real time), prior to meals for type 2 diabetes mellitus.During a surveyor interview on 11/25/2025 at 11:57 AM with Registered Nurse (RN), Staff D, she stated that the resident was receiving finger sticks, three times daily with meals, to obtain the resident's blood sugar levels.Record review failed to reveal evidence of an order to monitor blood glucose utilizing finger sticks, three times daily with meals, to obtain the resident's blood sugar levels.During an additional surveyor interview on 11/25/2025 at 2:30 PM, with RN, Staff D, she could not provide evidence the physician was notified that the Dexcom has stopped working and that they have been obtaining the resident's blood sugar through a fingerstick three times a day with meals.Record review failed to reveal evidence that staff have been accurately documenting the resident's blood sugar results, as staff continued to record the fingerstick glucose readings as if they were obtained from the Dexcom monitor. During a surveyor interview on 11/25/2025 at 1:28 PM with the Director of Nursing Services, he revealed that the resident's Dexcom glucose monitor stopped working on 11/21/2025. He acknowledged that the physician should have been notified that the Dexcom glucose monitor stopped working and an order to obtain the resident's blood sugar through fingerstick before meals should have been obtained.