STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415097	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mansion Nursing and Rehab Center	104 Clay Street Central Falls, RI 02863

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure that before a resident is transferred to a hospital or the resident goes on therapeutic leave that the facility provides written information to the resident or resident representative that specifies information about the bed hold policy, for Resident ID #1.Findings are as follows:Review of the facility's Bed Hold Policy, states in part, Whenever a resident is transferred from the facility for the purposes of hospitalization or therapeutic leave, the resident and/or representative is informed of the facility's policy concerning holding the bed. Review of a community reported complaint submitted to the Rhode Island Department of Health on 12/11/2025, alleges in part, the resident was not given the right medication/dosages, was not offered a bed-hold when sent out to the hospital for a behavioral health evaluation. Record review revealed Resident ID #1 was admitted to the facility in November of 2025 with diagnoses including, but not limited to, intertrochanteric fracture of left femur with surgical repair, sepsis secondary to cellulitis (a bacterial skin infection that causes redness, swelling, and pain, typically affecting the lower legs) of the left lower extremity, and on daily Methadone (a medication prescribed to treat opioid addiction) for an opioid use disorder.Further record review revealed that the resident was sent to the hospital on [DATE] after a verbal altercation with staff members. Further review of the record failed to reveal evidence that the resident was offered a bed-hold upon transfer to the hospital.During a surveyor interview with the Directo of Nursing (DON) on 12/16/2025 at 12:42 PM, she revealed the resident did not receive a bed-hold policy on transfer to the hospital. During a surveyor interview on 12/16/2025 at 3:00 PM with the Administrator, she was unable to provide evidence that Resident ID #1 was offered a bed-hold upon transfer to the hospital. Cross reference F 760

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on clinical record review and staff interview, the facility failed to ensure that residents are free of any significant medication errors for one of three residents reviewed, Resident ID #1.Findings are as follows:Review of a community reported complaint submitted to the Rhode Island Department of Health on 12/11/2025, alleges in part, that the resident did not receive his/her methadone (a medication prescribed to treat opioid addiction). Record review revealed Resident ID #1 was admitted to the facility in November of 2025 with diagnoses including, but not limited to, fracture of left femur with surgical repair, sepsis secondary to cellulitis (a bacterial skin infection that causes redness, swelling, and pain, typically affecting the lower legs) of the left lower extremity, and receives daily Methadone. Record review of the Medication Administration Record (MAR) for the month of November 2025, revealed a physician's order dated 11/25/2025 for Methadone Schedule II tablet, 40 milligrams (mg) once daily in the morning and 60 mg in once daily in the evening. Further review of the November 2025 MAR revealed the resident had not received Methadone on the following dates and times:~11/25/2025 40 mg AM dose~11/25/2025 60 mg PM dose~11/26/2025 40 mg AM dose~11/26/2025 60 mg PM doseDocumentation for all missed doses indicated Drug/Item unavailable as the reason.During a telephone interview on 12/16/2025 at 12:45 PM with the Director of Nursing (DON), she revealed that she faxed the orders for the Methadone on 11/24/2025 to the substance abuse treatment center, but they had already closed for the day. She also indicated that multiple calls were placed to the center and daily messages were left but the center wasn't calling the facility back. Additionally, the DON revealed that the Methadone didn't arrive until the residents' third day at the facility and there was concern for potential withdrawal symptoms from not having received the Methadone while at the facility. The DON revealed that on 11/26/2025 she had received a call at approximately 5:00 PM from the nurse on duty who explained that the resident had become verbally aggressive with her and that s/he was scaring the other residents. The DON advised the nurse to send the resident out for a behavioral health evaluation. During a surveyor interview on 12/16/2025 at 3:00 PM with the Administrator she was unable to provide evidence that Resident ID #1 was kept free from significant medication errors and acknowledged that the resident never received Methadone while residing at the facility.