STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415027	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adviniacare Pawtucket Pleasant Rehab Center, LLC	544 Pleasant Street Pawtucket, RI 02860

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 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. Based on clinical record review and staff interviews the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 1 of 1 resident reviewed with a physician's order for fluid restrictions, Resident ID #1.Findings are as follows:Record review revealed Resident ID #1 was re-admitted to the facility in December of 2025 with a diagnoses including, but not limited to, hypo-osmolality (a lower than normal concentration of sodium, electrolytes and proteins in the blood) and hypernatremia (when the sodium level in blood is low, which occurs when there's too much water or not enough sodium).Record review of the resident's care plan initiated on 11/21/2025 revealed the resident has a potential for fluid overload related to polydipsia (excessive thirst) and hyponatremia.Record review of the physician's orders revealed an order dated 12/12/2025 Encourage resident to limit fluid intake, every shift for monitoringRecord review of a progress note dated 12/22/2025 revealed that the resident was found on the floor in the bathroom with a large lump on his/her forehead. The resident was sent emergently to the hospital for an evaluation. Subsequently, the resident was admitted to the hospital with a diagnosis of hyponatremia.Record review of a hospital summary dated 12/22/2025 revealed the resident was admitted due to psychogenic polydipsia (excessive drinking of water) and was found to be hyponatremic. Lab results revealed hyponatremia of 119 (a normal blood sodium range is between 135 and 145 millimoles per liter (mmol/L) with a serum osmolality (the concentration of solutes in the liquid part of the blood) sodium of 252 (a normal range is 275-295). With a recommendation of a 1500 ml fluid restriction.Record review of a progress note dated 12/24/2025 revealed that the resident's Nurse Practitioner (NP) reviewed the fluid restriction with the resident and the importance of following it and for him/her to alert staff to any urinary retention. Additionally, the NP requested that Nursing staff to continue to monitor the resident's daily fluid intake and report acute changes to the provider, as the resident was hospitalized . The NP reinforced adherence to a 1500 mL per day fluid restriction. Record review of the physician's orders revealed an order dated 12/24/2025 Fluid Restriction 1500 ml Serve 1080 ml Dietary/Day. Dietary Amount per Meal: Breakfast: 480 ml Lunch: 240 ml Dinner: 360 ml Serve 420 ml for Nursing/Day Amount per Shift: 7-3 shift = 200 ml, 3-11 shift = 120 ml, 11=7 shift = 100 ml. every shift for Fluid RestrictionDuring a surveyor interview on 1/22/2026 at 8:36 AM with Nursing Assistant (NA), Staff A, he revealed that the NA's do not document or communicate with nursing, the amount of fluids consumed for any of the residents.During a surveyor interview on 1/22/2026 at 8:45 AM with Licensed Practical Nurse, Staff B, she revealed that the fluid intake for Resident ID #1 had been monitored and completed in his/her electronic record by the NA's and is signed off as completed by the nursing staff in his/her Treatment Administration Records (TAR). She acknowledged that there was no record of the amount of fluid that was provided per shift to the resident or the amount of the resident's fluid intake per shift as indicated by the physician's order for monitoring.Record review of the resident's TAR for December 2025 and January 2026 revealed the resident's orders for fluid (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415027	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER Adviniacare Pawtucket Pleasant Rehab Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 544 Pleasant Street Pawtucket, RI 02860	

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restrictions were documented as completed with a check mark.Further review of the record failed to reveal documentation of the amount of fluid the resident consumed per shift daily as ordered. During a surveyor interview on 1/22/2026 at 10:26 AM with the Medical Director, she revealed that she would expect the resident's fluid intake to be monitored and the amount s/he consumed would documented per shift as indicated in the physician's order.During a surveyor interview on 1/22/2026 at 10:44 AM with the Administrator, she acknowledged that the facility failed to monitor the resident's fluid intake per the physician's order.