STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415033	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adviniacare Newport, LLC	398 Bellevue Avenue Newport, RI 02840

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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 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, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety relative to the main kitchen and 2 of 3 nourishment units observed.Findings are as follows:1.Record review of the Food and Drug Administration (FDA) Food Code 2022 Edition, Section 3-501.17 states in part, .refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked .The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety .Surveyor observations during the initial tour of the main kitchen on 12/16/2025 at 9:35 AM, revealed eight, one-quart cartons of cultured buttermilk with a use by date of 12/8/2025.During a surveyor interview with the Food Service Director (FSD) immediately following the above observation, she acknowledged that the cartons of buttermilk were expired and should be discarded.2.Record review of the FDA Food Code 2022 Edition, Section 4-601.11 states in part, .NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris .Additional review of the FDA Food Code 2022 Edition, Section 3-307.11 state in part, .FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306 .During a surveyor observation of the second-floor nourishment unit on 12/19/2025 at 10:39 AM, the following were observed:- A packaged tuna fish sandwich in the refrigerator without a label or date.- The inside of the microwave had brown food matter stuck to the ceiling and walls in addition to a greasy residue on the door. The rotating plate was also covered in a brown liquid.During a surveyor interview with Nursing Assistant, Staff M, immediately following the above observation, she acknowledged the sandwich was not labeled and should be. Additionally, she acknowledged that the microwave was dirty and should be cleaned.During a surveyor observation of the third-floor nourishment unit on 12/19/2025 at approximately 11:00 AM, the following were observed:- In the freezer, there was a 16 oz Styrofoam cup with a plastic bag inside which appeared to contain milk. The cup was labeled Don't touch please in Spanish.- The inside of the microwave had rust lining the edges of the ceiling. The rust flaked off when touched.During a surveyor interview with Licensed Practical Nurse, Staff B, immediately following the above observation, she acknowledged that the microwave had rust on the inside. Additionally, she indicated that the milk in the freezer was breast milk belonging to another staff member and should not be stored in the resident's freezer.During a surveyor interview with the FSD on 12/19/2025 at 11:07 AM, she acknowledged that the second-floor microwave should be cleaned and that the third-floor microwave should be replaced. Additionally, she indicated that she would expect all food to be labeled and that food/personal items belonging to staff member should not be stored in the resident's refrigerator or freezer.

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on clinical 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, related to 2 of 2 certified medication technicians (CMT) evaluations reviewed, Staff N and O. Findings are as follows:Record review of the QAPI binder on 12/19/2025 at 12:00 PM with the Administrator and Regional Director of Nursing Services, revealed a performance improvement plan was implemented on 6/17/2024 to establish a tracking system for employee evaluations which included CMT evaluations. This tracking failed to reveal evidence that the quarterly evaluation for CMTs, Staff N and O, were completed until it was brought to their attention by the surveyor during the survey.During a surveyor interview on 12/19/2025 at 12:00 PM with the Regional Director of Nursing Services, she was unable to provide evidence that the facility implemented and maintain an effective QAPI program.Cross reference: RI state 1.16.10.B.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on surveyor observation, staff and resident interview, the facility failed to provide a private space for resident council meetings that are held monthly as required. Findings are as follows:During the resident council interview task on 12/17/2025 at 1:18 PM with 14 residents in attendance, collectively they indicated that they are not given privacy when having their regular resident council meetings. The residents indicated that the meetings are typically held in the 1st floor dining room, where the current meeting was being held. Surveyor observations during the resident council meeting on 12/17/2025 from 1:18 PM until approximately 1:55 PM, staff interrupted the meeting at the following times:-1:20 PM - a staff member entered the room and went into the kitchenette area. -1:25 PM - the Director of Nursing Services (DNS) entered the room to get water from the cooler.-1:30 PM- the DNS entered the room again and went into her office, which is adjacent to the dining room area. -1:38 PM - a staff member entered the room to use the sink. -1:50 PM - a staff member entered the room for an unknown reason.During a surveyor interview on 12/18/2025 at 1:18 PM with the Activities Director, she indicated that she is aware that staff frequently interrupts the resident council meetings, however the facility does not have another area for the residents to conduct a private meeting. Additionally, she indicated that she would expect the facility to provide a private space for the residents to conduct the resident council meetings.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interviews, the facility failed to follow and implement physician's orders related to the facility's Bowel Evacuation Protocol for 2 of 2 residents reviewed who did not have a bowel movement for over three days, Resident ID #s 78 and 11. Findings are as follows:Review of a facility policy titled, Bowel Evacuation Protocol dated March 2016, states in part, The facility has the responsibility to ensure that each resident develops regular bowel habits with or without cathartic assistance.to prevent impaction and.promote psychological and social well-being.If the resident has had no bowel movement for 9 consecutive shifts, begin the bowel protocol on the 3:00 PM to 11:00 PM shift. The Bowel protocol is to give Milk of Magnesia (MOM) on the 3:00 PM to 11:00 PM shift. If the MOM is ineffective, then the resident is to receive a Bisacodyl suppository on the 11:00 PM to 7:00 AM shift. If the Bisacodyl suppository is ineffective, then the resident is to receive a Fleets enema on the 7:00 AM to 3:00 PM shift. Record the results of the Bowel Protocol.Notify the physician if the Bowel Protocol is ineffective . 1. Record review revealed Resident ID #78 was admitted to the facility in March of 2025 with a diagnosis of severe protein-calorie malnutrition. Further review revealed this resident was receiving hospice services. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident requires maximum assistance with activities of daily living (ADLs) including toileting and is in incontinent of bowel and bladder.Record review revealed the following nursing notes:12/7/2025- The resident was awake for most of the overnight shift with frequent medical complaints. The resident stated s/he .had non-stop bubbles down the left side of [his/her] abdomen and flatulence that was not normal . 12/8/2025- The resident was seen by the Physician's Assistant, and he ordered an abdominal X-ray (KUB- Kidney, Ureter, and Bladder X-Ray) to rule out a bowel obstruction.Record review revealed a progress note dated 12/9/2025 indicating that the nurse called the hospice supervisor to notify her that the KUB was ordered. Further review revealed .Nursing supervisor at hospice does not approve orders, they will not be paid for by hospice. Message left for PA [Physician's Assistant] to review .Record review revealed a provider's order dated 12/9/2025 for a KUB. Record review failed to reveal evidence that the KUB was completed as ordered. Review of the bowel movement (BM) record revealed the resident did not have a BM from 12/13/2025 through 12/17/2025, which is five days. Record review of the December 2025 Medication Administration Record (MAR) revealed the following orders:-3/20/2025- Milk of Magnesia (MOM)- administer 30 milliliters orally as needed if no BM for three days.-3/20/2025- Dulcolax (Bisacodyl) Suppository- administer 10 milligrams rectally as needed if no BM from MOM.-3/20/2025- Fleet Enema- administer 1 enema rectally as needed if no results from Dulcolax suppository, give fleet enema on the 4th day.Further review of the MAR failed to reveal evidence that any of the above medications were administered after three days without a bowel movement as ordered until it was brought to the facility's attention by the surveyor on 12/18/2025. During a surveyor interview on 12/18/2025 at 12:00 PM with Registered Nurse, Staff F, she indicated that she did not have a bowel list printed at that time and was unaware if anyone was on the bowel list. After requested by the surveyor, she was unaware how to print the bowel list and required assistance from another staff member. She acknowledged that Resident ID #78 had not had a bowel movement recorded in five days and no interventions were implemented as ordered. Additionally, she acknowledged that Resident ID #78 did not have the KUB completed as ordered. During a surveyor interview on 12/19/2025 at 1:13 PM with the Hospice Nursing Supervisor, she indicated that obtaining a KUB would not affect the resident's eligibility for hospice services and that it can be billed to a non-hospice insurance. During a surveyor interview on 12/19/2025 at 1:49 PM with PA, Staff C, he indicated that he had not been made aware that the KUB had not been completed and would have expected the KUB to have been completed as ordered.During a surveyor interview on 12/19/2025 at 2:29 PM with the Director of Nursing Services (DNS), she indicated that she would have expected the nurse to have called the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provider back to clarify the order for the KUB, after speaking with the hospice team. Additionally, she could not provide evidence that the bowel protocol had been followed as ordered. 2. Record review revealed Resident ID #11 was admitted to the facility in May of 2025 with diagnoses including, but not limited to, adult failure to thrive and constipation. Record review of the MDS assessment dated [DATE] revealed a Brief Interview for Mental Status score of 12 out of 15, indicating moderately impaired cognition. Further review revealed the resident is incontinent of bowel and bladder and is dependent on staff for ADLs, toileting and hygiene. During a surveyor interview on 12/16/2025 at approximately 10:30 AM, Resident ID #11 indicated that s/he should be having bowel movements more often and indicated s/he had not received any medication to assist with having a bowel movement. Review of the resident's BM record revealed the resident did not have a bowel movement for five days, from 12/13/2025 through 12/17/2025. Review of the December 2025 MAR revealed the following orders: -5/7/2025- Milk of Magnesia (MOM)- administer 30 milliliters orally as needed if no BM for three days.-5/7/2025- Dulcolax (Bisacodyl) Suppository- administer 10 milligrams rectally as needed if no BM from MOM.-5/7/2025- Fleet Enema- administer 1 enema rectally as needed if no results from Dulcolax suppository, give fleet enema on the 4th day.Record review failed to reveal evidence that MOM was administered after three days without a BM. Further review revealed MOM was administered on the fifth day without a BM on 12/17/2025. Additional review failed to reveal that any additional medications were administered as ordered or that the provider was notified per the facility's policy. During a surveyor interview on 12/18/2025 at 12:00 PM with Registered Nurse, Staff F, she indicated that she did not have a bowel list printed at that time and was unaware if anyone was on the bowel list. After requested by the surveyor, she was unaware how to print the bowel list and required assistance from another staff member. She acknowledged that Resident ID #11 had not had a bowel movement recorded in five days and no interventions were implemented as ordered. During a surveyor interview on 12/19/2025 at 2:29 PM with the DNS, she could not provide evidence that the bowel protocol had been followed as ordered. Cross Reference F 684

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure the residents' environment remains as free of accident hazards as possible, related to securing medications and hazardous equipment (razor) for 1 of 1 treatment cart observed on a secured unit in close proximity to Resident ID #s 9 and 14, and for 1 of 2 smokers reviewed without a smoking assessment, Resident ID #21.Findings are as follows:1. During a continuous surveyor observation on 12/16/2025 of the third-floor (the secure unit) nursing treatment cart located in the hallway, it was observed to be unlocked while unattended by staff for seventeen minutes from 10:37 AM to 10:54 AM.Record review revealed Resident ID #9 was admitted to the facility with a diagnosis of dementia. Further record review revealed a Brief Interview for Mental Status (BIMS) score of 3 of 15, indicating a severely impaired cognition.During a surveyor observation on 12/16/2025 at approximately 10:00 AM revealed Resident ID #9 wandering in the hallways, self-propelling in his/her wheelchair.Record review revealed Resident ID #14 was admitted to the facility with a diagnosis of Alzheimer's disease. Further record review revealed a BIMS score of 0 of 15, indicating severely impaired cognition.During a surveyor observation on 12/16/2025 at approximately 10:00 AM revealed Resident ID #14 walking around the hallways independently.During a surveyor observation on 12/16/2025 at 11:03 AM of the treatment cart with Licensed Practical Nurse (LPN) Staff B, treatment medications such as diclofenac gel, antifungal creams, hemorrhoidal cream, and a box of clean razors were being stored in the treatment cart.During a surveyor interview with Staff B, following the above observation, she acknowledged that the cart was left open and would expect it to be locked when unattended. During a surveyor interview on 12/18/2025 at 1:17 PM with the Director of Nursing Services (DNS), she was unable to provide evidence that the residents' environment in the secured unit was maintained as free of accident hazards as possible, as required.2. Record review of the smoking policy states in part, .Residents who smoke will be evaluated for their ability to smoke safely upon admission, quarterly and . to ensure that they continue to be capable of smoking and use smoking materials without presenting a danger to themselves or others.Clinical record review revealed Resident ID #21's Occasional/Former Smoker Evaluation dated 3/14/2025, revealed that s/he wishes to smoke, and continued to be on the facility's list of smokers provided to the surveyor on 12/16/2025.Record review failed to reveal evidence that the resident was evaluated for his/her smoking capabilities quarterly on 6/14/2025 and 9/14/2025.During a surveyor interview on 12/19/2025 at approximately 1:00 PM with the DNS, she acknowledged that the resident failed to be re-evaluated for his/her smoking capabilities quarterly, as required.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, staff and resident interviews, the facility failed to provide a safe, functional, sanitary and comfortable environment for resident's relative to 1 of 1 privacy curtain observed with staining, and for 2 of 3 units reviewed without an assigned housekeeper.Findings are as follows:1.Record review revealed Resident ID #94 was admitted to the facility in March of 2024 with a diagnosis including, but not limited to, dementia.During a surveyor observation of the resident's room on 12/16/2025 at 10:35 AM, the privacy curtain between the resident's bed and his/her roommate was observed to have large, brown stains that were splattered across the length of the curtain.A subsequent observation of the resident's room on 12/19/2025 at 12:54 PM revealed that the privacy curtain still had the staining and had not been changed.During a surveyor interview with Nursing Assistant, Staff Q, immediately following the above observation, she acknowledged that the resident's privacy curtain had scattered brown staining and was dirty.During a surveyor interview with Licensed Practical Nurse, Staff B on 12/19/2025 at 1:38 PM, she acknowledged that the privacy curtain was dirty and would expect that it would be cleaned by laundry and housekeeping.During a surveyor interview with the Director of Nursing Services on 12/19/2025 at 1:31 PM, she revealed that the privacy curtain should have been removed and cleaned by the housekeeping staff.2.During surveyor observations on the following dates and times, flies were observed in common areas and in occupied residents' rooms:- 12/16/2025 at 10:22 AM, inside room [ROOM NUMBER]- 12/16/2025 at approximately 11:00 AM, second floor outside the nurses' station- 12/16/2025 at 2:54 PM, inside room [ROOM NUMBER]Record review of the October and November 2025 resident council meeting minutes revealed that there were flies in resident rooms and in the common areas. During the resident council interview task on 12/17/2025 at 1:42 PM, several residents indicated that housekeeping is a problem, with only one housekeeper on duty most of the time. They indicated the second floor often goes a week or longer without bathrooms being cleaned, floors swept, trash emptied, or paper products refilled.Record review of the Resident Bed List Report dated 12/16/2025 revealed the following census by floor:- First floor: 25 residents- Second floor: 41 residents- Third floor: 35 residentsRecord review of the staffing schedule for housekeeping from 12/7 through 12/20/2025 revealed there was one housekeeper scheduled for the entire building on 12/7, 12/8, 12/9, 12/10, 12/13, 12/15, and 12/16, and this housekeeper was scheduled to work only on the first floor.Additional record review revealed there were only two housekeepers scheduled to work in the facility on 12/11 and 12/18/2025. These housekeepers were assigned on the first and third floors.During a surveyor interview with the Director of Maintenance on 12/19/2025 at approximately 10:01 AM, he indicated that he was aware of the residents' concerns related to housekeeping services. However, he was unable to provide evidence that there were more than one housekeeping staff scheduled on the dates mentioned above, to maintain a clean, sanitary, and comfortable environment for the residents.During a surveyor interview with Housekeeper, Staff R, on 12/19/2025 at 10:01 AM, she indicated that when she is on schedule, she only cleans the first floor and does not clean second and third floors.During a surveyor interview with Housekeeper, Staff S, on 12/19/2025 at 10:20 AM, she revealed she works part time on the third floor and does not work on the first and second floors.During a surveyor interview with the Regional Director of Nursing on 12/19/2025 at 10:30 AM, she acknowledged that the facility does not have sufficient housekeeping staff to provide residents with a safe, functional, sanitary and comfortable environment.

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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 clinical record review and staff interview, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, relative to physician's orders for 1 of 3 residents reviewed who receives Eliquis (a medication prescribed to prevent and treat blood clots), Resident ID #64.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.Record review revealed the resident was admitted to the facility in July of 2023 with a diagnosis including, but not limited to, acute embolism and thrombosis of unspecified deep veins of the right lower extremity (a health condition when blood clots form in the vessels blocking blood flow).Record review of the Electronic Medical Record (EMR) revealed a physician's order dated 12/12/2025 for Eliquis 5 milligrams twice daily.Record review of the paper Medication Administration Record (MAR) revealed that the Eliquis order was written as discontinued on 12/16/2025.Record review failed to reveal evidence that the order was discontinued by the provider on 12/16/2025.During a surveyor interview on 12/19/2025 at 9:40 AM with Licensed Practical Nurse, Staff D, she acknowledged that the resident's Eliquis order is still active in the EMR.Record review of the paper MAR failed to reveal evidence that the Eliquis was administered for 5 opportunities from 12/16/2025 through 12/19/2025.During a surveyor interview on 12/19/2025 at 11:30 AM with the Director of Nursing Services, she was unable to provide evidence that the Eliquis administered as ordered. She acknowledged that the order should not have been discontinued on 12/16/2025.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, staff, and resident interview, the facility failed to provide activities of daily living (ADL) care for 1 of 1 resident reviewed for who receives hospice services, Resident ID #78.Findings are as follows:Record review revealed Resident ID #78 was admitted to the facility in March of 2025 with diagnoses including, but not limited to, severe protein-calorie malnutrition, major depressive disorder, cataracts (a condition which includes the clouding of the eye's lens which can lead to blurred vision and blindness), and adult failure to thrive. Further review revealed this resident was receiving hospice services. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating moderately impaired cognition. Further review revealed the resident required maximum assistance with ADLs including personal hygiene, bathing and toileting due to incontinence of bowel and bladder. During a surveyor interview on 12/16/2025 at approximately 11:15 AM with Resident ID #78, the resident stated that s/he was very uncomfortable because s/he had not had ADL care provided that morning or the day before (12/15/2025 and 12/16/2025). The resident indicated that a hospice aide usually comes in but had not been there in two days and the facility staff had not provided ADL care to him/her. Additionally, the resident indicated that s/he was angry because s/he should have been cleaned and dressed by the time of the interview. During a surveyor interview on 12/16/2025 at 11:39 AM with Nursing Assistant (NA), Staff A, she indicated that she thought that a hospice aide usually provides ADL care for the resident, but they had not been into the facility yet. She further acknowledged that the resident had not had ADL care provided at the time of the interview. Record review of the ADL documentation failed to reveal evidence that the resident had received ADL care on the day shift of 12/15/2025 and 12/16/2025, which includes toileting hygiene, bathing, and dressing. During a surveyor interview on 12/17/2025 at 3:08 PM with Registered Nurse, Staff E, she indicated that a hospice NA comes to the facility once a week to provide care for the resident, not daily. She could not provide evidence that the resident received care on the 1st shift of 12/15/2025 and on the morning of 12/16/2025, prior to the surveyor bringing it to the staff's attention. During a surveyor interview on 12/19/2025 at 2:29 PM with the Director of Nursing Services, she indicated that she would expect staff to document when ADL care is provided. Additionally, she could not provide evidence that Resident ID #78 received ADL care on the 1st shift of 12/15/2025 and 12/16/2025, prior to the surveyor bringing it to staff's attention. Cross Reference: F 684

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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 clinical record review and staff interview, the facility failed to provide appropriate treatment and services for 1 of 2 residents reviewed with an indwelling foley catheter (a flexible tube that collects urine from the bladder and empties into a drainage bag) related to urine output monitoring, Resident ID #10.Findings are as follows:According to Brunner & Suddarth's Textbook of Medical-Surgical Nursing, Volume 2, 10th Edition, page 252 states, .the usual daily urine volume in the adult is 1-2 Liters or 1000-2000 cubic centimeters (cc) [milliliters] . Additionally, page 1282 states, For patients with indwelling catheters, the nurse assesses the drainage system to ensure that it provides adequate urinary drainage. The color, odor, and volume of urine are also monitored. An accurate record of fluid intake and urine output provides essential information about the adequacy of renal function and urinary drainage .Record review of a policy titled URINARY CATHETER CARE dated April of 2015 states in part, .empty drainage bag at least every 8 hours and as necessary.Record review revealed the resident was admitted to the facility in December of 2024 with a diagnosis including, but not limited to, urinary retention.Record review revealed a physician's order dated 10/3/2025 to monitor catheter drainage every shift.Record review of a document titled, Vital Reports from 11/18/2025 through 12/18/2025 failed to reveal evidence that the resident's urine output was recorded for 36 of 90 opportunities. Additional review failed to reveal evidence that the resident's urine output was recorded in milliliters to accurately monitor his/her output every shift for 21 of 90 opportunities.During a surveyor interview on 12/19/2025 at 1:27 PM with Nursing Assistant (NA), Staff G, she acknowledged that they are required to empty the resident's urinary catheter bag, measure the amount of urine in the bag, and document the amount in milliliters in the resident's record every shift.During surveyor interview on 12/19/2025 at 1:31 PM with the Director of Nursing Services, she acknowledged that the NAs are responsible for emptying the urinary catheter bags, measuring the amount of urine in the bag, and documenting the amount of urine in milliliters in the resident's record every shift.

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	415033	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adviniacare Newport, LLC	398 Bellevue Avenue Newport, RI 02840

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure residents who are fed through a feeding tube receive the appropriate treatment and services to prevent complications for 1 of 1 resident reviewed for a continuous feeding via a jejunal tube (J-tube, a surgically placed device used to give direct access to the small intestine for supplemental feeding, hydration or medicine), Resident ID #13. Findings are as follows: According to Lippincott Nursing Procedures Nineth Edition dated 2023, states in part, .Managing Enteral Tube Feeding Problems.Aspiration of gastric secretions.Elevate the head of the bed a minimum of 30 degrees.Review of a facility policy dated April 2015 titled Enteral Feeding [feeding provided through an alternative method via a J-tube] states in part, .Elevate head of bed 30-45 degrees.Label formula and administration set with date, time, resident's name and nurse initials.Always keep HOB [head of bed] elevated to prevent aspiration.Record review revealed that Resident ID #13 was admitted to the facility in August of 2024 with diagnoses including, but not limited to, adult failure to thrive and gastroesophageal reflux disease (a chronic digestive condition where the stomach acid frequently flows back up into the canal that connects the throat to the stomach). Record review revealed physician's orders dated 8/1/2024 to elevate the resident's head of bed at 30 degrees continuously and to change the enteral feeding bag once a day. During surveyor observations on 12/16/2025 at 10:30 AM, 11:15 AM, and at 12:52 PM, the resident was observed lying flat while receiving enteral feeding via the J-tube and the head of the bed was not elevated at 30 degrees, as ordered. Additional surveyor observations on 12/18/2025 at 9:25 AM and at 9:30 AM, the resident was observed lying flat while receiving content from a bag via the J-tube that was not labeled with the content or dated, as per the facility's policy. During a surveyor observation and interview on 12/18/2025 at 9:32 AM and at 9:52 AM with Registered Nurse, Staff H, she acknowledged the resident was lying flat while receiving his/her enteral feeding via the J-tube. Staff H then exited the room during the observation on 12/18/2025 at 9:32 AM without elevating the head of the bed after it was brought to her attention by the surveyor. Additionally, Staff H, acknowledged the enteral feeding bag was not labeled and dated, as required. During a surveyor interview on 12/18/2025 at 9:56 AM with the Director of Nursing Services (DNS), she indicated that she would expect the head of the bed to be elevated to at least 30 degrees when s/he is receiving his/her enteral feeding via the J-tube. Additionally, the DNS indicated that the bag containing the enteral feeding should have been labeled and dated.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure that each resident's medication regimen is free from a medication error rate of 5% or greater. Based on 25 opportunities for errors observed during the medication administration task, there were four errors resulting in an error rate of 16% affecting Resident ID #s 43, 81, 62 and 101.Findings are as follows: 1. Record review revealed Resident ID #43 has a physician's order for Carvedilol (a medication prescribed to treat several heart and blood vessel conditions by relaxing blood vessels and slowing the heart rate) 3.125 milligrams (mg) twice a day with parameters to hold for a heart rate less 60. During a surveyor observation on 12/18/2025 at 8:53 AM with Certified Medication Technician (CMT), Staff I, she was observed obtaining the resident's heart rate which was 42. Staff I then administered the Carvedilol to the resident. During a surveyor interview with Staff I, immediately following the above observation, she acknowledged the resident's heart rate was 42 and had administered the Carvedilol instead of holding it, as ordered. 2. Record review revealed Resident ID #81 has a physician's order for Humalog Kwik Pen insulin (a medication prescribed to treat diabetes) 100 unit/milliliter (ml) three times a day per sliding scale (a method of determining the dose of insulin to be administered based on a person's current blood sugar level). During a surveyor observation on 12/18/2025 at 11:36 AM with Registered Nurse (RN), Staff H, she was observed placing a needle on the insulin pen without sanitizing the hub (a rubber seal on the top of the insulin pen where the needle is inserted). Additionally, Staff H did not prime the needle and proceeded to administer the insulin to the resident. Manufacturer's instruction on the One-Care safety pen needles box revealed to prime the needle prior to administering insulin. During a surveyor interview with Staff H immediately following the above observation, she acknowledged that she did not sanitize the insulin pen hub prior to attaching the needle and she did not prime the insulin needle prior to administering the insulin to the resident, as required. 3. Record review revealed Resident ID #62 has a physician's order for Lispro insulin pen (a medication prescribed to treat diabetes) 100 units/milliliter (ml) 20 units daily.During a surveyor observation on 12/18/2025 at 11:45 AM RN, Staff J, was administering the resident insulin without priming the needle. Manufacturer's instruction on the One-Care safety pen needles box revealed to prime the needle prior to administering insulin. During a surveyor interview with Staff J immediately following the above observation, she acknowledged that she did not prime the insulin needle prior to administering the insulin to the resident, as required. 4. Record review of the December 2025 Medication Administration Record revealed Resident ID #101 received 10 units of Lispro via an insulin pen on 12/18/2025 at 11:45 AM. During a surveyor observation on 12/18/2025 at 11:45 AM with RN, Staff K administering the insulin to Resident ID #101 he did not prime the needle to the insulin pen. Manufacturer's instruction on the One-Care safety pen needles box revealed to prime the needle prior to administering insulin. During a surveyor interview with Staff K immediately following the above observation, he acknowledged that he did not prime the insulin needle prior to administering the insulin to the resident, as required. During a surveyor interview on 12/18/2025 at 1:27 PM with the Director of Nursing Services (DNS), she acknowledged Resident ID #43's Carvedilol should have been held for a heart rate of 42, as ordered. The DNS further indicated that would expect Staff H to have sanitized the insulin pen hub and primed the insulin needle prior to administering insulin to Resident ID #81. Additionally, she indicated that Staff J and Staff K should have also primed the insulin needle prior to administering the insulin.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on surveyor observation, clinical record review, and staff interview, 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], for 4 of 4 residents observed on EBP, Resident ID #s 12, 13, 22 and 65. 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.feeding tubes.Clean their hands, including before entering and when leaving the room .1. Record review revealed Resident ID #22 was admitted to the facility in December of 2025 with a diagnosis including, but not limited to, a wound on the right hand. During a surveyor observation on 12/16/2025 at approximately 10:30 AM revealed signage posted outside of Resident ID #22's room indicating s/he is on EBP. During a surveyor observation on 12/16/2025 at 10:46 AM, Nursing Assistant, Staff L, was observed dressing Resident ID #22 without wearing a gown per the facility's signage. Staff L then exited the room, went into the hallway, acquired a wheelchair and went back into the resident's room, then transferred the resident from the bed to the wheelchair without wearing a gown.During a surveyor interview immediately following the above observation with Staff L, he acknowledged that he had assisted the resident with dressing and transferring and failed to wear a gown as per the facility's signage. 2. Record review revealed Resident ID #13 was admitted to the facility in August of 2024 with a diagnosis including, but not limited to, an artificial opening of the gastrointestinal track status J-tube insertion (a surgically placed device used to give direct access to the small intestine for supplemental feeding, hydration or medicine). During a surveyor observation on 12/16/2025 at approximately 11:00 AM revealed signage posted outside of Resident ID #13's room indicating s/he is on EBP. During a surveyor observation on 12/16/2025 at 11:04 AM, Nursing Assistant, Staff L, was observed providing a bed bath for Resident ID #13 without wearing a gown as per the facility's signage.During a surveyor interview immediately following the above observation with Staff L, he acknowledged that he had given the resident a bed bath and failed to wear a gown. During a surveyor interview on 12/19/2025 at 12:03 PM with the Director of Nursing Services (DNS), she acknowledged that both Resident ID #s 13 and 22 are on EBP. The DNS further indicated that she would expect the staff to wear a gown and gloves when giving a bed bath, dressing, and transferring the residents as indicated on the signage.3. During a surveyor observation on 12/16/2025 at 10:56 AM with Laundry Aide, Staff P, she failed to sanitize her hands while dropping off clean laundry in between resident rooms who were on EBP. She was first observed going into Resident ID #12's room to drop off clean laundry, touched the cabinet in the room, then exited the room without sanitizing her hand. She then went back to the clean laundry cart, grabbed another set of clean clothing, went into Resident ID #65's room to drop off the clothing, she exited the room and did not sanitize her hands.During a surveyor interview following the above observation, Staff P initially indicated that she had utilized the hand sanitizers in Resident ID #s 12 and 65 rooms, however, the hand sanitizer dispensers in both rooms had been checked by the surveyor prior to this observation and both dispensers were empty. Staff P then acknowledged that she should have sanitized her hand between rooms, before and after dropping off laundry in resident rooms.During a surveyor interview on 12/18/2025 at 1:08 PM with the DNS, she was unable to provide evidence that the laundry aide maintained an infection prevention practice to help prevent the transmission of communicable diseases and infections.

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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 and record review, the facility failed to protect identifying information for 7 current residents listed in the facility's survey results binder for 2 of 4 surveys reviewed.Findings are as follows:During a surveyor observation on 12/17/2025 at approximately 1:45 PM of the first floor, a black binder with a title of State Survey Results was stored on a wall in the entrance to the facility, facing the public.Record review of the survey binder revealed resident rosters (a list provided to a facility that corresponds to a number identifier utilized in a survey to protect privacy) included with the statement of deficiencies for the following surveys:- Survey results for exit date 9/18/2025, identifying Resident ID #s 74 and 99- Survey results for exit date 9/6/2024, identifying Resident ID #s 12, 32, 60, 61, and 74Further record review of the above surveys with the attached rosters contained information including, but not limited to, physician's orders and medical diagnoses.During a surveyor interview on 12/17/2025 at 2:05 PM with the Administrator, he acknowledged that the residents' names along with their corresponding number identifiers were in the binder and should not be available to view.