STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415035	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincolnwood Rehabilitation and Healthcare Center	610 Smithfield Road North Providence, RI 02904

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 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, resident and staff interview, it has been determined that the facility failed to ensure that services being provided meet professional standards of practice relative to following physician's orders for 1 of 2 residents recently admitted to the facility, Resident ID #3. Findings are as follows:Record review revealed the resident was admitted to the facility in June of 2025 with diagnoses including, but not limited to, end stage renal disease, dependence on renal dialysis (a medical treatment to remove waste and fluids from the blood when the kidneys do not function properly) and constipation.Record review of the July 2025 admission Minimum Data Set Assessment revealed a Brief Interview for Mental Status score of 15 out of 15, indicating the resident is cognitively intact.Record review of the admission Transfer/Discharge Report dated 6/26/2025 revealed an order for Polyethylene Glycol 3350 (Miralax; a medication prescribed to treat constipation) 17 grams (gm) by mouth every 24 hours as needed (PRN) for constipation, hold for loose stools.Record review of the physician's orders revealed an order with a start date of 6/27/2025 for Miralax 17 gm, give one packet by mouth every morning, hold for loose stools. Record review of the June and July 2025 Medication Administration Records (MARs) revealed the resident was administered Miralax every morning instead of PRN since his/her admission.Record review of the physician's orders revealed that the above-mentioned order for Miralax was discontinued on 7/16/2025.During a surveyor interview on 7/17/2025 at 2:54 PM with Licensed Practical Nurse (LPN), Staff A, when asked why the Miralax order had been discontinued on 7/16/2025, Staff A revealed that she had changed the order from daily to PRN after the resident had requested it to be ordered PRN. Additionally, she acknowledged that the Miralax was initially supposed to be transcribed as PRN but was transcribed as daily instead.During a surveyor interview on 7/17/2025 at 2:58 PM with the nurse that transcribed the admission order for the Miralax, LPN, Staff B, she revealed that after reviewing the admission orders, she inaccurately transcribed the Miralax order as daily, and it should have been transcribed as PRN.During a surveyor interview on 7/18/2025 at 12:58 PM with the resident, s/he revealed that after being admitted to the facility, s/he received Miralax daily. The resident further revealed that s/he recently requested that the medication be made PRN as s/he never receives this medication daily prior to his/her admission to the facility and only has taken it PRN. Additionally, the resident denied that s/he had ever requested for the medication order to be changed to daily upon admission. Record review of the progress notes failed to reveal evidence that the admission order for Miralax PRN was ever changed by the provide upon admission to the facility to daily. During a surveyor interview on 7/18/2025 at approximately 2:00 PM with the Regional Clinical Director and the Director of Nursing Services, they were unable to provide evidence that the resident received the Miralax medication as ordered from 6/27/2025 to 7/16/2025.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review and staff interview, it has been determined that the facility failed to ensure that residents who require dialysis (a medical treatment that removes waste and fluids from the blood when the kidneys do not function properly) receive such services, consistent with professional standards of practice relative to following the physician's orders for a fluid restriction and medication administration for 1 of 3 residents reviewed, Resident ID #2. Findings are as follows: Record review revealed the resident was admitted to the facility in July of 2025 with diagnoses including, but not limited to, end stage renal disease, dependence on renal dialysis and fluid overload. Record review revealed the resident receives dialysis weekly every Tuesday, Thursday, and Saturday. 1a. Record review revealed a physician's order dated 7/7/2025 for a 1000 milliliter (ml) fluid restriction, indicating to provide the allowed fluid intake per the physician's order and document the total amount consumed every shift. Additionally, the order revealed a breakdown of fluids to include a total of 280 ml daily from nursing, with 120 ml from the first and second shifts and 40 ml from the third shift and a breakdown of fluids from dietary to include 720 ml daily, with 240 ml at each meal. Record review of the July 2025 Medication Administration Record (MAR) failed to reveal evidence that the resident's total daily fluid intake was documented from 7/7/2025 to 7/17/2025. Further review of the record revealed that only the nursing fluid intake was documented. During a surveyor interview on 7/18/2025 at 9:43 AM with Licensed Practical Nurse (LPN), Staff C, she was unable to provide evidence of the resident's total daily fluid intake. During a surveyor interview on 7/18/2025 at 9:55 AM with the Unit Manager, Staff D, she revealed that they do not document intake and output. Additionally, she was unable to provide evidence of the resident's total daily fluid intake. 1b. Record review revealed a physician's order dated 7/3/2025 for Sevelamer Carbonate (a medication prescribed to lower high blood phosphorus levels by binding to dietary phosphate in the digestive tract, preventing its absorption) 800 milligrams (mg) three times daily with meals. Record review of the July 2025 MAR revealed that on 7/5, 7/8, 7/10, 7/12 and 7/15/2025 the resident was not administered the prescribed Sevelamer Carbonate on his/her dialysis days at 11:30 AM. Additionally, the MAR had a code of 3 documented for those dates and times, which indicated that the medication was not administered due to the resident being Absent from facility. Record review of the electronic medication administration record, under resident details, indicated the resident was not administered the Sevelamer Carbonate on the above-mentioned dates. Record review of the progress notes failed to reveal evidence that a provider was notified that the resident did not receive Sevelamer Carbonate as ordered on the above-mentioned dates. During a surveyor interview on 7/18/2025 at 9:43 AM and 10:35 AM with LPN, Staff C, she acknowledged that the resident did not receive the Sevelamer Carbonate on the above-mentioned dates and times, as the resident receives dialysis at that time and s/he eats his/her meal after dialysis at approximately 4:00 PM, which is too close to the next dose. Additionally, she revealed that she did not inform the provider that the medication was not administered by her on 7/8, 7/10, or 7/12/2025. During a surveyor interview on 7/18/2025 at approximately 2:00 PM with the Regional Clinical Director and the Director of Nursing Services, they were unable to provide evidence that Resident ID #2's fluid restriction of 1000 ml daily was followed and that the resident received his/her Sevelamer Carbonate as ordered.

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. (continued on next page)

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**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 that the resident's physician completed a medication reconciliation upon admission, failing to identify a medication transcription error, resulting in the resident receiving Dilantin (a medication prescribed to treat seizures) in error on 18 occasions without a diagnosis of a seizure disorder, instead of receiving the intended medication, Diltiazem (a medication prescribed to treat high blood pressure) which was not transcribed. Additionally, the resident was transferred to the hospital where s/he received emergent hemodialysis (a medical treatment to remove waste and excess fluids that the kidneys are unable to perform this function adequately) for the Dilantin use, Resident ID #1.Findings are as follows:Record review of a community reported complaint submitted to the Rhode Island Department of Health on [DATE] alleges that Resident ID #1 was administered the medication Dilantin, instead of the prescribed medication Diltiazem for his/her heart condition, after recovering from a cardiac stent surgery. Additionally, the complainant indicated that the resident's condition was getting worse, believing that the Dilantin caused his/her death.Record review revealed the resident was readmitted to the facility following a hospital admission in December of 2024 with diagnoses including, but not limited to, hypertension (high blood pressure), heart failure and post-cardiac surgery. Additional review of the record failed to reveal evidence that the resident had a diagnosis of a seizure disorder. Record review of the hospital continuity of care (COC) document dated [DATE] revealed a physician's order to continue the medication Diltiazem 30 milligrams (mg) by mouth three times a day. Additional review of the COC failed to reveal evidence of a physician's order for Dilantin.Review of the facility's admission orders revealed a physician's order dated [DATE] for Dilantin 30 mg three times daily, noted as being prescribed for atherosclerosis of native arteries of extremities with rest pain, right leg. This diagnosis does not constitute an appropriate indication for the use of Dilantin.Record review of a progress note dated [DATE], authored by the resident's physician, Staff E, revealed he personally reviewed the resident's records including the acute care hospital, the skilled nursing facility and the therapy records. Additional review of the progress note failed to reveal evidence that the physician identified that the Dilantin was ordered in error.During a surveyor interview on [DATE] 1:55 PM with the resident's physician, he acknowledged that he assessed the resident on [DATE], the day after his/her readmission to the facility. He indicated that he reviewed the resident's hospital discharge summary document, including the medication orders. Additionally, he acknowledged that he failed to review the resident's medication orders that were transcribed into the facility system upon his/her admission, and he failed to reconcile the facility's orders with the hospital's discharge orders. Furthermore, he revealed that he did not identify that the medication Dilantin was transcribed instead of the ordered Diltiazem.Record review of the [DATE] and [DATE] Medication Administration Records (MARs) revealed the resident mistakenly received the medication Dilantin instead of the ordered Diltiazem 18 times since his/her admission. Additional review of the [DATE] and [DATE] MARs revealed that the resident was administered Dilantin on multiple dates by eight different nurses. Dilantin is prescribed to treat seizure disorders, yet the documented diagnosis was atherosclerosis of native arteries. In contrast, the resident had a cardiac diagnosis that would have more appropriately aligned with the use of Diltiazem, highlighting a clear mismatch between the prescribed medication and the resident's clinical condition. This indicates multiple missed opportunities including the physician to identify and correct the medication error.Record review of a progress note dated [DATE] at 11:02 AM authored by the Unit Manager, Staff D, revealed that the resident's medication Diltiazem 30 mg three times a day was incorrectly transcribed as Dilantin 30 mg three times a day.Record review of a nursing progress note dated [DATE] indicates that Resident ID #1 presented with a change in mental status, weakness and was hypotensive (low blood pressure) and s/he was transferred and admitted to the hospital. During a surveyor interview with the Director of Nursing Services on [DATE] at 2:24 PM, she was unable to provide evidence that the resident's physician completed a medication reconciliation upon his/her admission to the facility. Record review of the hospital paperwork revealed the resident was admitted to the intensive care unit, received emergent hemodialysis for phenytoin [Dilantin] use. The resident coded on [DATE] and was provided high quality cardiopulmonary resuscitation and s/he subsequently expired on [DATE] at 12:38 PM. As a result of this survey, it was determined that Resident ID #1 was placed at risk for serious harm, injury, impairment, or death due to the facility's failure to ensure the resident's physician completed a medication reconciliation upon admission which contributed to a transcription error

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**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 that residents are free of any significant medication errors for 1 of 1 resident reviewed who received Dilantin (a medication prescribed to treat seizures) in error on 18 occasions without a diagnosis of a seizure disorder, instead of receiving the intended medication, Diltiazem (a medication prescribed to treat high blood pressure) which was not transcribed. Additionally, the resident was transferred to the hospital where s/he received emergent hemodialysis (a medical treatment to remove waste and excess fluids that the kidneys are unable to perform this function adequately) for the Dilantin use, Resident ID #1.Findings are as follows:Record review of a community reported complaint submitted to the Rhode Island Department of Health on [DATE] alleges that Resident ID #1 was administered the medication Dilantin instead of the prescribed medication Diltiazem for his/her heart condition after recovering from a cardiac stent surgery. Additionally, the complainant indicated that the resident's condition was getting worse, believing that the Dilantin caused his/her death.Review of a facility document titled Administering Medications stated in part, Medications are administered in a safe and timely manner.medications are administered in accordance with the prescriber's orders.Record review revealed Resident ID #1 was readmitted to the facility following a hospital admission in December of 2024 with diagnoses including, but not limited to, hypertension (high blood pressure), heart failure and post-cardiac surgery. Additional review of the record failed to reveal evidence that the resident had a diagnosis of a seizure disorder.Record review of his/her admission Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 15 out of 15, indicating the resident has intact cognition.Record review of the hospital continuity of care (COC) document dated [DATE] revealed a physician's order to continue the medication Diltiazem 30 milligrams (mg) by mouth three times a day. Additional review of the COC failed to reveal evidence of a physician's order for Dilantin.Review of the facility's admission orders revealed a physician's order dated [DATE] for Dilantin 30 mg three times daily, noted as being prescribed for atherosclerosis of native arteries of extremities with rest pain, right leg. This diagnosis does not constitute an appropriate indication for the use of Dilantin.Additional review of the [DATE] and [DATE] MARs revealed that the resident was administered Dilantin on multiple dates by eight different nurses. Dilantin is prescribed to treat seizure disorders, yet the documented diagnosis was atherosclerosis of native arteries. In contrast, the resident had a cardiac diagnosis that would have more appropriately aligned with the use of Diltiazem, highlighting a clear mismatch between the prescribed medication and the resident's clinical condition. This indicates multiple missed opportunities including the physician to identify and correct the medication error.Review of the Medication Administration Records for [DATE] and [DATE] revealed that the resident received Dilantin on multiple dates, administered by eight different nurses. This suggests there were numerous opportunities to recognize and address the medication error: - [DATE] - 3 times - [DATE] - 1 time - [DATE] - 3 times - [DATE] - 2 times - [DATE] - 3 times - [DATE] - 3 times - [DATE] - 3 timesRecord review revealed the resident received the medication Dilantin in error instead of the ordered Diltiazem, indicating the resident received the incorrect medication 18 times since his/her admission to the facility.Additional record review failed to reveal evidence that the resident received his/her Diltiazem as ordered. Record review of a nursing progress note dated [DATE] at 11:02 AM, authored by the Unit Manager, Staff D, revealed the resident's ordered medication, Diltiazem 30 mg three times a day, was incorrectly transcribed as Dilantin 30 mg three times a day.Record review of a nursing progress note dated [DATE] indicates that Resident ID #1 presented with a change in mental status, weakness and was hypotensive (low blood pressure) and was transferred and admitted to the hospital. During a surveyor interview on [DATE] at 1:34 PM with Staff D, she revealed that she transcribed an order for Dilantin 30 mg instead of the ordered Diltiazem 30 mg in error, on the day of his/her admission to the facility. Additionally, she acknowledged that while she was transcribing the admission orders, she failed to verify that the correct medication, Diltiazem, was transcribed as ordered. During a surveyor interview on [DATE] at 1:55 PM with the resident's physician, he acknowledged that he assessed the resident on [DATE], the day after his/her readmission to the facility. He indicated that he reviewed the resident's hospital discharge summary document, including the medication orders. Additionally, he acknowledged that he failed to review the resident's medication orders that were transcribed into the facility system upon his/her admission, and he failed to reconcile the facility's orders with the hospital's discharge orders. Furthermore, he revealed that he