

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Lincolnwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff and resident 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 with a gastrojejunostomy tube (G-J tube, a specialized medical device that allows healthcare providers to access both stomach and small intestine through a single physical opening on the outside of the body, by having 2 separate access ports, a G-port to the stomach and a J-port to the small intestine), Resident ID #1. Findings are as follows: Record review of a report titled, Hospital Events Reporting received by the Rhode Island Department of Health on 6/17/2026, alleged that the facility failed to ensure proper maintenance of enteral feeding tubes for Resident #1. Resident #1 had a G-J tube placed on 5/8/2026 and while residing in the facility, the jejunal (J) portion of the tube repeatedly clogged, requiring consecutive replacements on 6/3/2026, 6/8/2026, and 6/13/2026. This recurrent failure and frequent invasive intervention resulted in documented resident frustration. Record review revealed the resident was admitted to the facility in July of 2026 with diagnoses including, but not limited to, malignant neoplasm of ascending colon (colon cancer), gastroparesis (a digestive disorder where the stomach takes too long to empty its contents), 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). Review of a Comprehensive 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. During a surveyor interview with the resident on 6/17/2026 at 11:00 AM, s/he alleged that staff has been mixing up the utilization of his/her G-J tube. S/he revealed that s/he utilizes the G-J tube, the G-port for receiving medications through his/her stomach, and the J-port for receiving his/her enteral nutrition (liquid nutrients and fluid directly into the gastrointestinal tract). Resident ID #1 alleged that some of the nurses have been administering medications through the J-port, which was contraindicated to his/her surgeon's orders. Review of the resident's hospital discharge notes dated 6/2/2026, revealed a physician's order to administer medications through the G-port and to utilize the J-port only for enteral feedings. Review of the nursing progress note dated 6/8/2026, authored by Registered Nurse (RN), Staff B, revealed that the resident's J-tube had difficulty flushing, was non-patent, and was unable to administer medications or feedings via J-tube due to subsequent obstruction. The resident was eventually sent to the emergency room (ER) for evaluation. Record review of the ER notes on 6/8/2026, revealed the resident's J-port was malfunctioning which was resolved in the ER and orders were provided to flush the feeding tube after each meal and before going to bed. During a surveyor interview on 6/17/2026 at 3:00 PM, with RN Staff B, in the presence of the DNS, regarding the resident's ER visit on 6/8/2026, Staff B was initially unable to identify which port of the G-J tube was obstructed. She stated that the proper ports for medication administration and enteral nutrition are specified within the physician's orders. During a surveyor interview on 6/17/2026 at 3:20 PM, with the Director of Nursing Services (DNS), she was unable to provide evidence that the resident received the appropriate treatment to prevent multiple ER visits related to the clogging of the J port of his/her G-J tube. On 6/18/2026, the (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
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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DNS provided the surveyor with a written statement authored by RN Staff B, dated 6/17/2026, describing the differences between a G-tube and a J-tube. In the statement, Staff B indicated that she had incorrectly documented her nursing progress note dated 6/8/2026 and intended to document that the G-port was occluded rather than the J-port. However, this statement was not provided until after surveyor interviews and requests for clarification regarding the resident's repeated tube obstructions. Furthermore, this statement is inconsistent with the hospital documentation from the resident's 6/8/2026 ER visit, which explicitly identified the J-port, not the G-port, as the obstructed line.		