

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

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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 07/20/2026
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.			
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure that residents are free of any significant medication errors for 1 of 3 residents reviewed for Morphine Sulfate solution (a medication prescribed to treat pain), Resident ID #1 and for 1 of 2 residents reviewed for insulin use, Resident ID #4. Findings are as follows: Review of a community reported complaint submitted to the Rhode Island Department of Health on 7/14/2026, alleged Resident ID #1 was transferred to the hospital after receiving 10 times the prescribed dose of Morphine Sulfate. Review of a facility policy titled, Administering Medications dated April of 2019, states in part, .Medications are administered in accordance with prescriber orders. Medication errors are documented, reported, and reviewed. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dose, right time, and right method (route) of administration before giving the medication. the individual administering the medication records in the resident's medical record: a. the date and time the medication was administered; b. the dosage; c. the route administered; d. the injection site (if applicable); e. any complaints or symptoms for which the drug was administered; f. any results achieved and when those results were observed; and g. the signature and title of the person administering the drug. Record review revealed the resident was admitted to the facility in October of 2023 with diagnoses including, but not limited to, acute and chronic respiratory failure and chronic pain disorder. Record review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 15 of 15, indicating intact cognition. Further review revealed that the resident frequently experience pain. Record review revealed a physician's order dated 6/29/2026, for Morphine Sulfate 10 milligrams (mg) per 5 milliliters (mL), administer 2.5 mL (5 mg) by mouth every six hours as needed for pain. Review of the Pyxis transaction report (a machine which dispenses medications) revealed Morphine Sulfate 100 mg/5mL was dispensed on 7/9/2026 at 12:37 PM, a concentration of medication which is 10 times more potent than the amount indicated in the order. Review of an E-Rx New Prescription Request dated 7/9/2026 revealed an order for Morphine Sulfate concentrate 100 mg/5 ml, take 1/4 ml by mouth every six hours as need for pain, 0.25 ml (5 mg). Record review of the July 2026 Medication Administration Record (MAR) failed to reveal evidence that the above-mentioned new prescription was transcribed into the resident's record. Record review of the narcotic administration book revealed that on 7/9/2026, 2.5 mL of Morphine Sulfate 100 mg/5 mL was administered to the resident at 12:45 PM. A total dose of 50 mg, 10 times the prescribed dose. Further review of the narcotic administration book (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	failed to reveal evidence that the directions for administration, dosage, route, date received, and date opened were documented. Record review failed to reveal evidence that the provider was notified of the above medication error until 7/10/2026, over 24 hours after ten times the prescribed dose of Morphine Sulfate was administered to the resident. Review of an Optum (a contracted ancillary healthcare provider network) clinical note dated 7/10/2026, authored by Optum Registered Nurse (RN), Staff C, revealed . This writer was returning a call to SNF (Skilled Nursing Facility); Nurse [Staff D] reported to this writer that [Resident ID #1] received wrong dose of medication. This writer asked which medication/dose and informed [Staff D] that this writer will be calling [Optum Nurse Practitioner (NP), Staff B]. Discussed with [NP, Staff B] about medication error in which [Staff B] wanted to do a three way call with [facility] nurse [Staff D]. Orders given by [NP, Staff B]. After further discussion, [Staff B] gave order to send out to hospital for monitoring and further eval due to medication error. Review of a Continuity of Care Consultation and Referral Form dated 7/10/2026 which was sent with the resident when transferred to the hospital, states in part, .Received wrong dose of morphine initially on 10 mg/5 mL and 2.5 ml to be given PRN (as needed) .2.5 mL [by mouth] was given from a bottle of morphine 100 mg/5 mL (10 times the initial dose). During a surveyor interview on 7/15/2026 at 12:47 PM with Resident ID #1, s/he revealed that s/he was given 10 times too much medication and was not told about the medication error until the facility was sending him/her to the hospital, over 24 hours later. The resident further revealed that after s/he was over dosed with morphine, s/he sat up in his/her wheelchair rocking and nodding off. During a surveyor interview on 7/15/2026 at approximately 10:45 AM with Licensed Practical Nurse (LPN), Staff F, he acknowledged that ten times the prescribed dose of Morphine had been administered to Resident ID #1 on 7/9/2026. He further revealed that a nurse must have another nurse present to obtain a narcotic from the Pyxis and at that time the two nurses should reconcile the medication on hand with the physician's order. The two nurses then sign the reconciled medication into the narcotic book together prior to administering the medication. During a surveyor interview on 7/16/2026 at 3:30 PM with Optum RN, Staff C, in the presence of the Optum NP Supervisor, she revealed that she was made aware that Resident ID #1 needed a refill for the Morphine Sulfate and contacted Optum NP, Staff B via text message to request a refill on behalf of the facility and the NP responded with a thumbs up emoji. She revealed that she later had a discussion with NP Staff B, at which time Staff B mentioned that she thought that the current dose was odd and was going to change the order. She further revealed that she did not contact the facility following the discussion with Staff B. Additionally, Staff C revealed that she was contacted by Licensed Practical Nurse (LPN), Staff D on 7/10/2026 at approximately 4:50 PM (over 24 hours after the medication error occurred) and was notified that Resident ID #1 had received 10 times the prescribed dose of Morphine. She revealed that she then contacted NP, Staff B and had a three-way call to include Staff B, Staff D, and herself to discuss the situation. She further revealed that Staff B gave an order to assess the resident, obtain his/her vital signs and to administer Narcan, as she was under the impression that the medication error had occurred that day. LPN Staff D then informed Staff B that Narcan was not available in the facility. Furthermore, she revealed that NP Staff B then provided an order to transfer Resident ID #1 to the hospital for further evaluation due to the overdose of Morphine Sulfate. During a surveyor interview on 7/15/2026 at 3:21 PM with RN, Staff G, he revealed that he was the charge nurse on 7/9/2026 and on 7/10/2026, on the 3:00 PM - 11:00 PM shift. He further revealed that on 7/9/2026 he was told by the 1st shift nurse that the resident received one dose of morphine for pain that day, however, he was not aware of the medication error until 10:00 PM. Additionally, he revealed that he told the 11:00 PM - 7:00 AM nurse to correct the discrepancy and did not notify the provider or supervisor of the overdose (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/9/2026 and was not transferred to the hospital until 7/10/2026, over 24 hours after the medication error and via non-emergent transport. Additionally, she revealed that she would expect a provider to be notified directly and immediately following a medication error and that nurses are to follow physician's orders.2. Record review revealed Resident ID #4 was admitted to the facility in December of 2025, with a diagnosis including, but not limited to, diabetes mellitus type 2. Record review of a Physician's order dated 3/16/2026 for blood glucose monitoring twice daily with instructions to call the provider if the blood glucose results are greater than 400 milligrams (mg)/deciliter (dl) (normal adult range 70-99 mg/dl). Record review of a progress note dated 7/13/2026 authored by LPN, Staff H, revealed a blood glucose reading of 410 mg/dl was obtained for the resident on 7/13/2026. Further review revealed a new order was given by the provider for a one-time dose of Humalog 4 units (a fast-acting insulin; a medication prescribed to treat high blood sugar) and to recheck the resident's blood glucose in 2 hours. Record review failed to reveal evidence that the Humalog order was transcribed for the resident. Record review of the July of 2026 MAR failed to reveal evidence that the resident received the 4 units of Humalog insulin or that his/her blood sugar was rechecked, as ordered. During a surveyor interview on 7/20/2026 at 11:07 AM with Licensed Practical Nurse, Staff D, she acknowledged that the record failed to reveal evidence that the 4 units of Humalog insulin was administered or that the resident's blood sugar was retaken, as ordered. During a surveyor interview on 7/20/2026 at 3:10 PM with the DNS, she was unable to provide evidence that the Humalog insulin was administered to Resident ID #4 or that the blood sugar was retaken, as ordered. Cross reference F710		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure residents were free from misappropriation of property relative to a narcotic medication for 1 of 1 resident reviewed with an opened medication bottle of Morphine Sulfate solution that had been found to be missing 1 milliliter (mL) of medication, but had not been administered to the prescribed resident, Resident ID #6. Findings are as follows: Review of a facility policy titled Controlled Substances last revised in November of 2022, states in part, Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services [DNS]. The [DNS] documents irreconcilable discrepancies in a report to the administrator. The administrator, consultant pharmacist, and/or [DNS] determine whether other action(s) are needed, e.g. [example] notification of police or other enforcement personnel. Record review revealed that Resident ID #6 was admitted to the facility in May of 2026 with diagnoses including, but not limited to, dementia and osteoarthritis. Record review revealed a physician's order dated 5/11/2026 for Morphine Sulfate solution 20 milligrams (mg) per 1 milliliter (mL), give 0.25 mL by mouth every four hours as needed for pain. Review of the May, June, and July 2026 Medication Administration Records (MAR) revealed the resident had not been administered the Morphine Sulfate solution. Review of the narcotic book revealed 15 mL of Morphine Sulfate solution 100 mg/ 5 mL (20 mg/1 mL) was received from the pharmacy on 5/12/2026. Further review revealed that on 6/13/2026 it was documented as being adjusted and the amount on hand was changed to 14 mL. Two nurses, Licensed Practical Nurse (LPN), Staff I and LPN Staff J signed the narcotic book as witnesses to the adjustment of the medication on hand. Additional review failed to reveal documentation of when the bottle had been opened. During a surveyor observation on 7/17/2026 at approximately 1:00 PM, in the presence of LPN, Staff I, Resident ID #6's Morphine Sulfate solution medication bottle was opened and appeared to contain approximately 14 mL of the medication. Staff I acknowledge the observation. During a surveyor interview on 7/17/2026 immediately following the above observation with Staff I, she revealed that she worked on the 7:00 AM - 3:00 PM shift on 6/11/2026 and the Morphine Sulfate solution medication bottle was sealed as when it was delivered. She further revealed that when she completed the narcotic count at the beginning of her 7:00 AM- 3:00 PM shift on 6/13/2026, she noticed that the bottle had been opened. She revealed that the medication had not been administered to the resident and the nurse who had worked the 11:00 PM - 7:00 AM shift, Staff J, was unaware of why the medication was opened. Additionally, she revealed that she notified the Unit Manager, Staff K, who instructed the nurses to adjust the medication on hand to 14 mL. The surveyor attempted to contact LPN, Staff J on 7/17/2026 at approximately 2:00 PM however, she was unavailable for an interview at that time. During a surveyor interview on 7/17/2026 at approximately 1:15 PM with the Unit Manager, Staff K, she revealed that she was notified of the discrepancy on the morning of 6/13/2026 and instructed the nurses to adjust the amount on hand. She further revealed that she thought the plastic seal may have fallen off and that the medication may have evaporated. Additionally, she revealed that she failed to notify the Administrator or the DNS. During a surveyor interview on 7/17/2026 at approximately 1:30 PM with the DNS, she revealed that she had not been made aware of the potential misappropriation of Resident ID #6's Morphine Sulfate solution and that an investigation had not been initiated by the facility, until after the concern was brought to the facility's attention by the surveyor.		

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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, resident, and staff interview, the facility failed to administer physician-ordered bolus tube feedings as prescribed to maintain an acceptable nutritional status for 1 of 1 resident reviewed who required enteral nutrition via feeding tube, Resident ID #2. Findings are as follows: Review of a community reported complaint submitted to the Rhode Island Department of Health on 6/30/2026, alleges in part, that Resident ID #2 requires tube feedings four times per day, has been losing weight, and is only receiving tube feedings twice per day. According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients. Review of the facility policy titled, Enteral Tube Feeding via syringe (bolus) [a bolus tube feeding is administered in a single, meal-sized amount of formula through a feeding tube] last revised in November of 2018 states in part, .The purpose of this procedure is to provide nutritional support to residents unable to obtain nourishment orally. Verify that there is a physician's order for this procedure. check the order to verify the type, amount. of administration. fill the syringe with prescribed amount of enteral feeding to be given. Documentation: The person performing the procedure should record the following information in the resident's medical record. Amount of feeding and amount of water administered. How the resident tolerated the procedure. If the resident refused the procedure, the reason(s) why and the intervention taken. Record review revealed Resident ID #2 was admitted to the facility in May of 2026 with diagnoses including, but not limited to, dysphagia (difficulty swallowing) following a stroke, protein calorie malnutrition and end stage renal disease. Additional record review revealed the resident receives dialysis in the dialysis den in the facility three times a week, on Mondays, Wednesdays and Fridays at 3:00 PM. Review of an admission Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 12 out of 15, indicating the resident has moderately impaired cognition. Further review revealed the resident requires tube feedings for his/her nutrition. During a surveyor interview on 7/15/2026 at 10:06 AM with the resident, s/he revealed that nursing staff had not consistently administered his/her prescribed tube feedings as ordered. The resident reported that, at times s/he had to notify nursing staff when his/her tube feeding was overdue, and that there were occasions when the prescribed tube feedings were not administered at all. Record review revealed the following physician's orders for Nepro (a specialized liquid supplement for nutrition):-6/3/2026 - 300 milliliters (mL) at 9:00 AM and 7:00 PM, 275 ml at 1:00 PM and 10:00 PM- order discontinued on 6/16/2026-6/16/2026 - 325 mL at 9:00 AM and 7:00 PM, 200 ml at 1:00 PM and 300 ml 10:00 PM- order discontinued on 6/20/2026-6/20/2026 - 325 mL at 9:00 AM and 7:00 PM, 200 ml at 1:00 PM and 300 ml 10:00 PM - order discontinued on 6/22/2026-6/22/2026 - 325 mL at 9:00 AM and 7:00 PM, 200 ml at 1:00 PM and 300 ml 10:00 PM - order discontinued on 6/23/2026-6/23/2026 - 350 mL at 9:00 AM and 7:00 PM, 250 ml at 1:00 PM and 325 ml at 7:00 PM and 10:00 PM - order discontinued on 7/9/2026 Record review of the June and July 2026 Medication Administration Record failed to reveal evidence that the resident received the prescribed Nepro on the following dates and times:-6/3/2026 at 1:00 PM, 7:00 PM and at 10:00 PM-6/15/2026 at 7:00 PM and at 10:00 PM-6/18/2026 at 7:00 PM-6/19/2026 at 1:00 PM-6/20/2026 at 10:00 PM-6/22/2026 at 1:00 PM and at 7:00 PM -6/23/2026 at 9:00 AM and at 1:00 PM-7/7/2026 at 10:00 PM During a surveyor interview on 7/15/2026 at approximately 12:45 PM and 3:45 PM with the dietitian, she acknowledged the above documentation (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and indicated that she was not aware that the resident had not received his/her tube feedings as ordered on the above dates and times, until it was brought to her attention by the surveyor. During a surveyor interview on 7/15/2026 at 1:30 PM with the Director of Nursing Services, she was unable to provide evidence that the resident received his/her tube feedings as ordered. During a surveyor interview on 7/20/2026 at 11:32 AM with the resident's Physician, he revealed that it would be his expectation for the resident to have received his/her tube feedings as ordered. Additionally, he indicated that it would be his expectation that if the resident is away from the facility for scheduled appointments, the order should be reviewed with the provider so the resident can receive the bolus feeding prior to leaving or upon return to the facility.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on clinical record review and staff interview, the facility failed to ensure that residents who are trauma survivors, receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences, and preferences, in order to eliminate, or mitigate triggers that may cause re-traumatization of the resident for 1 of 1 resident reviewed with a history of trauma, Resident ID #4. Findings are as follows: Review of a facility policy last updated in August of 2022, titled, Trauma Informed Care and Culturally Competent Care states in part, .Purpose. To address the need of trauma survivors by minimizing triggers and/or re-traumatization. Traumatic events which may affect residents during their lifetime include interpersonal or community violence. For trauma survivors, the transition to living in an institutional setting (and the associated loss of independence) can trigger profound re-traumatization. Triggers are highly individualized. provide universal screening of residents. Screening may include information such as trauma history, including type, severity and duration. Assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma as well as identification of triggers. Develop individualized care plans that address past trauma in collaboration with the resident and family. Record review revealed Resident ID #4 was admitted to the facility in December of 2025, with diagnoses including, but not limited to, vascular dementia, major depression, anxiety, and bipolar disorder (a mental health condition). Record review of a care plan with a start date of 7/10/2026 revealed the resident has a history of Post Traumatic Stress Disorder (PTSD; a mental health condition that develops after experiencing or witnessing a traumatic event, characterized by intrusive memories, avoidance, negative mood changes, and heightened arousal or reactivity) with interventions including, but not limited to, avoid situations that may cause flashbacks, ask the resident about his/her triggers and incorporate them into his/her plan of care. Review of the comprehensive care plan failed to identify triggers or include interventions to eliminate or mitigate triggers that may cause re-traumatization of the resident. Record review failed to reveal evidence that a trauma informed care assessment was completed following the identification that the resident had experienced a traumatic event in his/her past. During a surveyor interview on 7/20/2026 at approximately 9:50 AM, with the Social Worker, Staff L, she acknowledged that after she was made aware of the resident's trauma history, she failed to complete a trauma informed care assessment. Additionally, she revealed that she is unaware of how to complete a trauma informed care assessment for a resident with a newly identified trauma history. During a surveyor interview on 7/20/2026 at approximately 10:30 AM, with the Director of Nursing Services, she revealed it would be her expectation that a trauma informed care assessment would be completed for a resident with a newly identified history of trauma, to enable staff to identify and mitigate his/her triggers. Additionally, she could not provide evidence that a trauma informed care assessment was completed after 7/10/2026 to identify the resident's triggers or that the comprehensive care plan was revised to include interventions to eliminate or mitigate triggers that may cause re-traumatization.		

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. Based on clinical record review and staff interview, the facility failed to ensure the medical care of each resident was supervised by a physician when the ordering provider failed to communicate the discontinuation of a Morphine Sulfate (a narcotic; a controlled medication classified as an opioid, prescribed to treat severe pain) order and the initiation of a new more concentrated Morphine Sulfate order, for 1 of 1 resident reviewed, who was administered 10 times the prescribed dose of Morphine Sulfate and required transfer to the hospital for an evaluation, Resident ID #1. Findings are as follows: Review of a community reported complaint submitted to the Rhode Island Department of Health on 7/14/2026, alleges Resident ID #1 was transferred to the hospital after receiving 10 times the prescribed dose of Morphine Sulfate one day prior. Record review revealed the resident was admitted to the facility in October of 2023 with diagnoses including, but not limited to, acute and chronic respiratory failure and chronic pain disorder. Record review revealed a physician's order dated 6/29/2026 for Morphine Sulfate 10 mg/5 mL, give 2.5 mL by mouth every six hours as needed for moderate to severe pain, for a total dose of 5 mg. Review of an E-Rx New Prescription Request dated 7/9/2026 revealed on order for Morphine Sulfate concentrate 100 mg/5 mL, take 1/4 mL by mouth every six hours as need for pain, 0.25 mL/5 mg. Record review of the July 2026 Medication Administration Record (MAR) failed to reveal evidence that the 6/29/2026 Morphine Sulfate order for 10 mg/5 mL, give 2.5 mL was discontinued on 7/9/2026. Additional review failed to reveal evidence that the 7/9/2026 prescription for Morphine Sulfate concentrate 100 mg/5 mL, take 1/4 mL was transcribed in the resident's MAR that day. Record review of the narcotic administration book revealed that on 7/9/2026, 2.5 mL of Morphine Sulfate 100 mg/5 mL was administered at 12:45 PM. A total dose of 50 mg, 10 times the prescribed dose indicated in the active physician's order. Record review of an Optum (a contracted ancillary healthcare provider network) Clinical Note dated 7/10/2026 at 12:10 PM, authored by Optum Nurse Practitioner (NP), Staff A, revealed the NP assessed the resident on 7/10/2026 and the nurse reported no new concerns. Further review revealed the following new orders: -Repeat labs-Vital signs every shift for three days Record review failed to reveal evidence that the above-mentioned new orders were transcribed into the resident's record. During a surveyor interview on 7/16/2026 at approximately 1:30 PM with the Optum NP, Staff A, she revealed that she assessed the resident on 7/10/2026 for a routine follow up and had not been notified of the Morphine Sulfate overdose that occurred on 7/9/2026. During a surveyor interview on 7/16/2026 at 9:48 AM with Optum Nurse Practitioner, Staff B, she revealed that she was informed that Resident ID #1 was out of his/her Morphine Sulfate 10 mg/5 mL and required a new prescription to be sent to the pharmacy on 7/9/2026. She further revealed that she reviewed the resident's active Morphine order and decided that the concentration should be changed. She then sent a new prescription to the pharmacy for Morphine Sulfate concentrate 100mg/5mL, give 0.25 mL every six hours as needed for pain. Additionally, she revealed that she did not notify the facility or communicate that she had discontinued the previous Morphine order and sent a new prescription for Morphine Sulfate, which was 10 times the concentration of the previous dose. She revealed that instead of communicating the order changes with the facility, she only communicated with the Optum RN, Staff C. Furthermore, she revealed that she was informed on 7/10/2026 by Optum RN Staff C, that Resident ID #1 was administered 10 times the ordered dose of Morphine Sulfate, at which time LPN, Staff D, was contacted via telephone. Staff B stated that she was under the impression that the medication error had just occurred that day and so she provided orders to obtain an assessment, obtain vital signs, administer Narcan, and ultimately to transfer the resident to the hospital for an evaluation, as she (continued on next page)		

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

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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 07/20/2026
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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was informed that Narcan was not available in the facility. Staff B revealed that she failed to complete NP clinical notes on 7/9/2026 or on 7/10/2026. During a surveyor interview on 7/16/2026 at 3:30 PM with Optum RN, Staff C, in the presence of the Optum NP Supervisor, she revealed that she was made aware that Resident ID #1 needed a refill for the Morphine Sulfate and contacted Optum NP, Staff B via text message to request a refill on behalf of the facility and the NP responded with a thumbs up emoji. She revealed that she later had a discussion with NP Staff B, at which time Staff B mentioned that she thought that the current dose was odd and was going to change the order. She further revealed that she did not contact the facility following the discussion with Staff B. Additionally, Staff C revealed that she was contacted by Licensed Practical Nurse (LPN), Staff D on 7/10/2026 at approximately 4:50 PM (over 24 hours after the medication error occurred) and was notified that Resident ID #1 had received 10 times the prescribed dose of Morphine. She revealed that she then contacted NP, Staff B and had a three-way call to include Staff B, Staff D, and herself to discuss the situation. Additionally, she revealed that LPN Staff D reported that the resident was sleeping and that she had not completed an assessment on the resident or obtained vital signs. She further revealed that Staff B gave an order to assess the resident, obtain his/her vital signs and to administer Narcan, as she was under the impression that the medication error had occurred that day. LPN Staff D then informed Staff B that Narcan was not available in the facility. Furthermore, she revealed that NP Staff B then provided an order to transfer Resident ID #1 to the hospital for further evaluation due to the overdose of Morphine Sulfate. During a surveyor interview on 7/16/2026 at 11:46 AM with Unit Manager, Staff E, she revealed that the Optum RN assesses residents in the facility a few times a week. She further revealed that in some cases, the Optum NP will communicate only with the Optum RN and the Optum RN will communicate the new orders to the facility's staff. During a surveyor interview on 7/16/2026 at approximately 1:30 PM with the Optum NP Supervisor, she revealed that she would expect the NP to give orders directly to the facility's nurse. Additionally, she revealed that would expect the NP to document within 48 hours, if there is a change to the resident's plan of care. During a surveyor interview on 11/16/2026 at 11:35 AM with the Director of Nursing Services, she revealed that she would expect that the Optum NPs speak with the facility's staff directly when giving orders and that the facility nurse contacts the provider directly. Additionally, she could not provide evidence that the discontinuation and concentration change of Morphine Sulfate was communicated appropriately between the provider and the facility's nurse. Lastly, she was unable to provide evidence that the notification of the 10-fold Morphine overdose for Resident ID #1 was communicated directly to his/her provider. The facility's failure to ensure the provider communicated changes to the resident's plan of care to the facility's nursing staff, rather than to a Registered Nurse within their own organization, resulted in a significant breakdown in physician oversight, clinical communication, and the safe management of a controlled substance. As a result, Resident ID #1 received a 10-fold overdose of a prescribed opioid medication, requiring the resident being transferred to the hospital for an evaluation. The facility further failed to ensure timely and effective identification, assessment, intervention, and response to this serious medication error, demonstrating a failure to provide adequate physician supervision of the resident's medical care. This absence of appropriate physician oversight placed the resident at risk for serious injury, serious harm, serious impairment, or death. Cross reference F760		