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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415038	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adviniacare Providence Dodge Rehab Center, LLC	135 Dodge Street Providence, RI 02907

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, and resident and staff interviews, the facility failed to keep a resident free from physical abuse for 1 of 2 residents that was involved in a physical altercation that resulted in the victim sustaining injuries to his/her face, Resident ID #6. Findings are as follows:Review of a facility reported incident submitted to the Rhode Island Department of Health on 1/7/2026 revealed that on 1/6/2026 at 9:00 AM two residents, Resident ID #s 6 and 7, were heard screaming in their room; staff immediately rushed to the room to separate them. Additionally, one of the residents, Resident ID # 6, was noted to have blood on his/her lower and upper lips.Review of a facility policy, untitled and last revised on 10/23/2022 states in part, .the facility prohibits the mistreatment.and abuse of residents.the facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident.abuse. According to the document, abuse is defined as the willful infliction of injury.with resulting physical harm, pain, or mental anguish.Record review revealed Resident ID #6, the victim, was admitted in December of 2023 and readmitted to the facility in January of 2026 with diagnoses including, but not limited to, end stage renal disease, anemia and dependence on renal dialysis.Record review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident is cognitively intact. Further review revealed the resident is dependent on staff for all activities of daily living.Record review of the care plan revised on 7/29/2024 revealed that Resident ID #6 exhibits behaviors related to verbal aggression with an intervention to monitor episodes of such behaviors. Additional review of the care plan dated 11/5/2025 revealed that Resident ID #6 requires assistance from staff with activities of daily living and mobility, related to a decrease in activity tolerance.Record review of the nursing progress notes for Resident ID #6 revealed the following:-1/6/2026 at 3:57 PM, authored by the resident's provider revealed in part, she noted that the resident sustained a lump to his/her left cheek, bruising to the right side of his/her face, and his/her upper and lower lips related to an alleged altercation with his/her roommate this morning.-1/6/2026 at 10:10 PM, authored by Licensed Practical Nurse (LPN), Staff A, revealed in part, that at approximately 9:00 AM staff heard screaming from the residents' room and rushed there to find Resident ID #7 (the perpetrator) standing in front of Resident ID #6 (the victim) holding his/her meal tray. Additionally, Resident ID #6 stated that Resident ID #7 hit his/her in the face and Resident ID #6 was noted to have a cut to both his/her upper and lower lips.Review of the skin evaluation dated 1/6/2026 for Resident ID #6, after the incident revealed the following:-Swelling to his/her eye-A laceration to the upper and lower lips, mild facial swelling, and blood noted.Record review revealed that Resident ID #7, the perpetrator, was admitted to the facility in January of 2018 and readmitted in March of 2025 with diagnoses including, but not limited to, anxiety disorder and delusional disorder.Review of the quarterly MDS assessment dated [DATE] revealed a BIMS score of 11 out (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of 15, indicating the resident has moderate impaired cognition.Review of the care plan revised on 8/1/2024 indicated that Resident ID #7 exhibits behaviors including verbal aggression and increased agitation. Interventions include, but are not limited to, staff to intervene when the resident becomes agitated, document all behaviors and attempt to identify a pattern to target interventions, and encourage the resident to take medications as ordered.Review of the nursing progress notes for Resident ID #7 revealed the following:-12/18/2025, the resident has had an increase in agitation and aggressive behaviors toward staff and a new recommendation for Trazodone (a medication prescribed to treat anxiety and depression) 50 milligrams (mg) twice daily has been initiated.-12/29/2025, the resident has been throwing his/her meal tray on the hallway floor despite having been re-directed several times to leave the tray in his/her room-12/30/2025, the resident continues to throw his/her meal tray in the hallway causing all the plates to shatter. The resident is not able to be redirected, and s/he is non-compliant with re-education regarding safety-1/1/2026, the resident was observed throwing his/her meal tray on the hallway floor despite being asked to leave it on the table for staff-1/6/2026, the resident had violent behavior when s/he had an alleged altercation with his/her roommate, and s/he was relocated to a different room1/6/2026, the resident reported that s/he asked his/her roommate to close the door to their room, but his/her roommate refused, and s/he struck his/her roommateRecord review of the Psychiatric team evaluations for Resident ID #7 revealed the following:-12/30/2025, the resident continues to exhibit restlessness and agitation with care. Plan, continue to monitor and document changes in mood, behavior disturbance and anxiety-1/6/2026, the resident assaulted his/her roommate. The resident has been non complaint with his/her medications.Review of a physician's order dated 12/16/2025 indicates to monitor Resident ID #7's behaviors and document the number of episodes every shift.Review of January 2026 Treatment Administration Record failed to reveal evidence that Resident ID #7 had behaviors on 1/6/2026 when s/he was involved in a physical altercation with his/her roommate. During a surveyor interview on 1/21/2026 at 10:55 AM with Resident ID #7, s/he revealed that s/he punched his/her roommate in the face.During a surveyor interview on 1/21/2026 at 11:01 AM with Resident ID #6, s/he revealed that Resident ID #7 hit him/her multiple times on the head and his/her face while s/he sat in his/her wheelchair after Resident ID #7 asked him/her to close their bedroom door and s/he refused. Further, Resident ID #6 revealed that his/her roommate had been physically aggressive towards him/her in the past and the facility was aware of this.During a surveyor interview on 1/21/2026 at 11:15 AM with Staff A, she revealed that on 1/6/2026 at approximately 9:00 AM, staff heard Resident ID #6 scream, and they rushed to his/her room to find Resident ID #6 sitting in his/her wheelchair with bloody lips and a puffy right sided face. Additionally, Resident ID #6 indicated that s/he was hit by Resident ID #7, who was observed standing in front of him/her. Staff A also revealed that Resident ID #7 has a history of aggressive behaviors.During a surveyor interview on 1/21/2026 at approximately 3:00 PM and 1/22/2026 at approximately 12:00 PM with the Administrator and the Director of Nursing Services (DNS), they acknowledged that Resident ID #7 has a history of aggressive behaviors. The Administrator and the DNS indicated that they were made aware of the altercation between both resident's, which resulted in Resident ID #6 sustaining bloody lips and a swollen face and Resident ID #7 was moved to a private room immediately following the incident. Additionally, they were unable to provide evidence that Resident ID #6 was kept free from abuse.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on clinical record review and staff interview, the facility failed to provide appropriate treatment and services for a resident who sustained a fall in the facility, was treated with antibiotics for a urinary tract infection (UTI), and subsequently fell again and later was admitted to the hospital with sepsis (a life threatening, emergency response to infection where the immune system triggers widespread inflammation, leading to potential organ failure, shock, and death) for 1 of 2 residents reviewed for falls, Resident ID #12.Findings are as follows: Review of a facility reported incident submitted to the Rhode Island Department of Health on 12/26/2025 revealed that on 12/24/2025, Resident ID #12 had fallen transferring him/herself from the bathroom, was noted to have a change in condition following the fall and was transferred to an acute care hospital where s/he was admitted for sepsis. Additionally, s/he had recently completed a course of intravenous (IV) antibiotics at the facility secondary to a UTI.1a. Record review revealed Resident ID #12 was readmitted to the facility in January of 2026 with diagnoses including, but not limited to, sepsis and bacteremia (the presence of bacteria in your blood which can be serious and requires antibiotics).Record review revealed the resident had an unwitnessed fall on 11/20/2025.Review of a progress note dated 11/20/2025 at 8:30 AM authored by the Nurse Practitioner (NP), Staff C, revealed that the resident was seen for an unwitnessed fall and increased confusion. Additionally, Staff C ordered blood work and a urine sample to be obtained to evaluate for any underlying causes.Record review revealed a urine sample was obtained on 11/21/2025, however the lab determined the urine specimen was suggestive of contamination and to repeat testing if it was clinically indicated. Additionally, it indicated the method of specimen collection was a clean catch (the least invasive way to collect a urine sample).Review of a progress note dated 11/24/2025 revealed Staff C had reviewed the bloodwork and urine specimen and ordered another urine specimen to be collected.Record review revealed a second urine sample was obtained on 11/25/2025, however the lab determined the urine specimen was suggestive of contamination and to repeat testing if it was clinically indicated. Additionally, it indicated the method of specimen collection was a clean catch.Review of a provider order dated 11/26/2025 with a start time of 11:00 PM revealed to obtain a urine specimen via straight catheterization (a method to collect urine that involves inserting a thin, flexible tube called a catheter through the urinary tract opening and into the bladder) to rule out a UTI every shift. Additional instructions indicated to discontinue the order once the specimen is obtained.Further review revealed a progress note dated 11/28/2025 at 12:59 PM indicated that the urine specimen was collected, the resident tolerated the procedure well, and the lab was contacted to pick up the urine specimen.Review of a progress note dated 12/1/2025 revealed the result of the urine specimen collected on 11/28/2025 was positive for a UTI with two organisms growing a colony count of greater than 100,000 (indicative of a significant bacterial load). Additionally, the resident was to begin antibiotic therapy that included two antibiotics and a probiotic.Further review of the progress notes revealed a note dated 12/2/2025 at 11:15 AM authored by Staff C that revealed the resident is to receive vancomycin (an antibiotic) 1 gram (g) intravenously twice daily at 9:00 AM and 9:00 PM for 12 days. Additionally, staff were to monitor the vancomycin trough levels (Refers to the lowest concentration of the antibiotic in the bloodstream before the next dose is administered. Vancomycin trough levels are crucial for ensuring effective treatment with target levels typically ranging from 10 to 20 mg/L [milligrams per liter] depending on the severity of the infection) before the fourth dose with an ideal trough level of 15-20 mg/L.1b. According to an article in the National Library of Medicine titled, Therapeutic Monitoring of Vancomycin in Adult Patients: A Consensus Review of the American Society of Health-System Pharmacists, the Infectious Diseases Society (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of America, and the Society of Infectious Diseases Pharmacists states in part, Optimal Trough Concentration for Complicated Infections.Vancomycin serum trough concentrations of 15-20 mg/L are recommended to improve penetration, increase the probability of obtaining optimal target serum concentrations and improve clinical outcomes.Review of the December 2025 Medication Administration Record revealed the resident received vancomycin from 12/2 through 12/14 with varying dosages based on the vancomycin trough level as follows:-12/2 9:00 PM through 12/10 9:00 AM: Vancomycin 1 gram-12/10 9:00 PM through 12/12 9:00 AM: Vancomycin 1,250 mg-12/12 9:00 PM through 12/14 9:00 PM: Vancomycin 1 gramRecord review failed to reveal evidence that a vancomycin trough level was obtained prior to each fourth dose on the following dates and times:-12/4/2025 before 9:00 AM-12/6/2025 before 9:00 AM-12/8/2025 before 9:00 AMRecord review revealed the first vancomycin trough level was initially obtained on 12/10/2025, indicating 3 opportunities to obtain a vancomycin trough level as indicated by the NP were missed.Review of the vancomycin trough level lab document dated 12/10/2025 revealed that the trough level was 12.1 mg/L and was not within the 15-20 mg/L therapeutic range as desired.Review of a progress note dated 12/10/2025 at 2:39 PM authored Staff C revealed the trough level was 12.1 mg/L, and the vancomycin dose was increased from 1 g to 1,250 mg.Record review revealed the resident completed his/her course of antibiotic therapy for his/her UTI on 12/14/2025.Review of progress notes dated 12/24/2025, 10 days following the completion of his/her antibiotic therapy for a UTI, revealed that the resident experienced a fall, was bleeding from his/her genital area, presented not at baseline and was shaky, unable to stand.pale, and s/he was subsequently transferred to an acute care hospital and was admitted with sepsis.Review of the hospital documentation dated 1/2/2026 revealed that the resident presented with a concern for sepsis with the focus of infection deemed to be urinary. Additionally, the resident received broad spectrum antibiotics, including vancomycin, as well as 2 L of fluids and 1 unit of blood.During a surveyor interview on 1/23/2026 at approximately 11:20 AM with Staff C, she revealed that she would expect the staff to have obtained the vancomycin trough levels after the 3rd dose and before the 4th dose to ensure that the vancomycin trough levels remain within the therapeutic target range of 15-20 mg/L. Additionally, she acknowledged that the vancomycin trough levels were not completed on 12/4, 12/6, and 12/8 before 9:00 AM and should have been, and that the vancomycin trough level on 12/10/2025 was subtherapeutic.During a surveyor interview on 1/23/2026 at approximately 1:10 PM with the Director of Nursing Services, she was unable to provide evidence that facility provided appropriate treatment and services for a resident diagnosed with a UTI who subsequently fell and was admitted to an acute care hospital for sepsis.During a surveyor interview on 1/23/2026 at approximately 4:00 PM with a facility pharmacy representative, he revealed that there is probably a higher likelihood of failing to destroy an infectious organism if the vancomycin trough levels are sub-therapeutic.Cross reference F 881

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it has been determined that the facility failed to ensure that a resident who requires dialysis (a medical treatment that filters waste products, toxins, and excess fluid from the blood when kidneys have failed) receive such services consistent with professional standards of practice, for 1 of 1 resident reviewed who was prescribed the medication Sevelamer (a medication prescribed primarily to treat elevated phosphorus levels in the blood for individuals with chronic kidney disease and are on dialysis) to treat his/her elevated blood phosphorus levels. This failure resulted in Resident ID #6's blood phosphorus level to further rise. Findings are as follows:Record review revealed the resident was readmitted to the facility in January of 2026 with diagnoses including, but not limited to, end stage renal disease (the final stage of chronic kidney disease when the kidneys can no longer function on their own) and dependence on renal dialysis.Record review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident is cognitively intact. Further review of the MDS indicated that the resident is dependent on staff for all activities of daily living.Review of the resident's care plan revised on 3/14/2024 indicated that the resident requires hemodialysis three times a week related to end stage renal disease, with an intervention including, but not limited to, coordinate medications with dialysis days.Record review revealed a physician's order dated 10/1/2025 for Sevelamer 3200 milligrams (mg) three times a day for hyperphosphatemia (an elevated blood phosphorus level). Record review of the November and December 2025 and the January 2026 Medication Administration Records failed to reveal evidence that the resident received the medication Sevelamer as ordered on the following dates and times:11/3/2025 - 12 PM11/4/2025- 8 AM11/5/2025 -12 PM11/10/2025- 12 PM11/12/2025- 12 PM11/14/2025- 12 PM11/28/2025- 12 PM12/3/2025 - 5 PM12/4/2025- 8:00 AM, 12:00 PM and 5:00 pm12/5/2025- 8:00 AM and 12:00 PM12/7/2025- 5:00 PM12/8/2025- 8:00 AM, 12:00 PM and 5:00 PM121/10/2025- 12:00 PM12/12/2025- 12:00 PM12/17/2025- 12:00 PM12/21/2025- 12:00 PM12/23/2025- 12:00 PM12/28/2025- 12:00 PM12/30/2025- 12:00 PM1/14/2026- 4:30 PM1/15/2026- 7:30:00 AM, 11:30 AM and 4:30 PM1/16/2026- 4:30 PM1/17/2026- 11:30 AM and 4:30 PM1/18/2026- 7:30 AM, 11:30 AM and 4:30 PM1/19/2026- 7:30 and 11:30 AM1/20/2026- 11:30 AM1/21/2026- 11:30 AMThe MARs indicate that the resident failed to receive the medication Sevelamer for a total of 27 doses, over the course of 3 months.Record review of the phosphorus levels from the hemodialysis center indicated on 12/19/2025 the resident had an elevated phosphorus serum level of 5.5 (the normal range for phosphorus levels are 2.5-4.5). Additional review of the document revealed that the resident's phosphorus level on 1/12/2026 was now 7.5, indicating his/her phosphorus level had increased 2 mg/deciliter (dl) and was now 3 mg/dl higher than the normal level.During a surveyor interview on 1/23/2026 at approximately 2:00 PM with Registered Nurse (RN), Staff B, she revealed that the resident's Sevelamer has not been available for a while to administer to him/her. Additionally, Staff B revealed that the medication Sevelamer was also put on hold because it was not available however, they recently received the medication last week from the hemodialysis center.During a surveyor interview on 1/23/2026 at 2:22 PM with the hemodialysis center staff RN, she revealed that the Sevelamer is ordered to be administered to the resident three times a day with meals. Additionally, she indicated that the hemodialysis center was unaware that the resident had ran out of Sevelamer, and that the facility had not communicated this to the hemodialysis center as they provide this medication to the facility. During a surveyor interview on 1/23/2026 at 2:34 PM with the Nurse Practitioner (NP), she indicated that she was made aware that the resident had missed doses of the Sevelamer. Additionally, the NP stated, the increased phosphorus levels are due to (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[him/her] not receiving the medication.During a surveyor interview on 1/23/2026 at 3:10 PM with the Director of Nursing Services (DNS), she revealed that she was initially unaware that the resident was receiving his/her medication supply of Sevelamer from the hemodialysis center and she was recently made aware that the resident could obtain the medication from the dialysis center. Additionally, the DNS was unable to provide evidence that the resident was administered the Sevelamer, as ordered.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to establish an Infection Prevention and Control Program (IPCP) that must include, at a minimum, an antibiotic stewardship program which includes antibiotic use protocols and a system to monitor antibiotic use to ensure that residents who require an antibiotic, are prescribed the appropriate antibiotic for 1 of 2 residents reviewed for antibiotic use, Resident ID #12.Findings are as follows:Review of a facility reported incident submitted to the Rhode Island Department of Health on 12/26/2025 revealed that on 12/24/2025, Resident ID #12 had fallen transferring him/herself from the bathroom, was noted to have a change in condition following the fall and was transferred to an acute care hospital where s/he was admitted for sepsis. Additionally, s/he had recently completed a course of intravenous (IV) antibiotics at the facility secondary to a urinary tract infection (UTI).Review of a facility policy titled, ANTIBIOTIC STEWARDSHIP last revised 9/10/2025, states in part, .Antibiotic will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. Antibiotic Stewardship refers to a set of commitments and activities designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use.If an antibiotic is indicated, prescribers will provide complete antibiotic orders including.duration of treatment start and stop date number of days of therapy.Record review revealed Resident ID #12 was readmitted to the facility in January of 2026 with diagnoses including, but not limited to, sepsis and bacteremia (the presence of bacteria in your blood which can be serious and require antibiotics).Record review revealed that the resident tested positive for a UTI and the provider ordered vancomycin (an antibiotic) 1 gram every 12 hours for 12 days beginning on 12/2/2025, indicating the resident was to receive a total of 24 doses.Review of an Antibiotic Time Out assessment dated [DATE], completed by the Infection Preventionist (IP), revealed that the vancomycin ordered for the resident was reviewed with the resident's Nurse Practitioner, Staff C. Review of the December 2025 Medication Administration Record revealed the resident received 25 doses of the vancomycin instead of the 24 doses that were prescribed.During a surveyor interview on 1/23/2026 at approximately 11:20 AM with Staff C, she revealed that she was unaware that the resident received an extra dose of his/her vancomycin. During a surveyor interview on 1/23/2026 at approximately 1:10 PM with the IP, in the presence of the Director of Nursing Services, she acknowledged completing the antibiotic time out for the vancomycin and failed to identify that the resident was scheduled to receive an additional dose of vancomycin.