

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: 415042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Adviniacare Waterview Villas, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1275 South Broadway East Providence, RI 02914	
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 0690 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to provide appropriate treatment and services for 1 of 1 resident reviewed with a foley catheter (a hollow, partially flexible tube that collects urine from the bladder and leads to a drainage bag), Resident ID #1, and for 1 of 1 resident with a suprapubic catheter (SP tube, a medical device that drains urine from the bladder through a small incision in the abdomen), Resident ID #2. Findings are as follows: Record review of a community reported complaint submitted to the Rhode Island Department of Health on 6/11/2026 alleges that Resident ID #1 has a foley catheter and had recently been hospitalized related to poor foley catheter care by the nursing facility. The report further alleges that the resident was injured when the foley was replaced by the facility nurse pushing on his/her stomach while trying to insert the foley catheter and asked to be sent to the hospital. The resident was sent to the hospital on 6/9/2026 and admitted with diagnoses of a urinary tract infection (UTI) and sepsis (a life-threatening organ dysfunction caused by an infection). 1. Record review revealed that Resident ID #1 was readmitted to the facility in June of 2026 with diagnoses including, but not limited to, urinary retention, UTI due to a foley catheter, and sepsis. Review of a care plan created on 4/20/2026 revealed that Resident ID #1 requires a foley catheter related to a diagnosis of urinary retention. Interventions include, but are not limited to, changing the foley catheter per the physician's orders. Record review revealed the following physician's orders: 4/28/2026: Urology consultation ordered related to new medications and use of a foley catheter for urinary retention. 5/14/2026: Indwelling catheter 16 French, change as needed. Record review revealed the following nursing progress notes: 4/19/2026: Foley catheter initiated related to urinary retention. 4/20/2026: New order for Flomax (a medication prescribed to relax the muscles in the prostate and bladder so that urine can flow easily) 0.4 milligrams daily. 4/28/2026: New order for a urology appointment due to recent foley catheter and medication. Record review of progress note authored by the Physician's Assistant (PA) dated 4/29/2026 states in part, .requires urology consult, consider void trial of the foley catheter. Record review failed to reveal evidence that a urology appointment had been scheduled for Resident ID #1. Record review revealed that the resident was admitted to the hospital from [DATE]- 5/14/2026 with diagnoses of sepsis secondary to catheter associated UTI. Record review of a hospital document titled, Discharge Summary dated 5/14/2026 states in part, .presented for evaluation of fever and shivering .there was concern over the patient's foley not being exchanged frequently enough. Foley catheter was exchanged on 5/6 and should be replaced every 8 weeks. Record review of progress note authored by the PA dated 5/15/2026 revealed that the resident requires a urology referral related to difficulty voiding and his/her recent hospital admission for a UTI and sepsis. Record review of the nursing progress notes revealed the following: 5/16/2026: The resident tested positive for a UTI and required an antibiotic. 6/7/2026: The resident complained of abdominal pain, his/her abdomen was noted to be distended, and the tip of his/her genital was noted to be split with white drainage. Hematuria (blood in urine) was also noted in the foley bag. 6/9/2026: Gross hematuria and mucus in urine, new order was given to hold his/her blood thinner medication and obtain labs. 6/10/2026: (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 0690 Level of Harm - Actual harm Residents Affected - Few	Resident noted with abdominal distention, leukocytosis (high white blood cells which could indicate significant bacterial infection) and gross hematuria. A new order was given to send the resident to the hospital. Record review revealed that the resident was readmitted to the hospital from [DATE] to 6/12/2026 with a diagnosis of a UTI due to a foley catheter and sepsis. Record review of a hospital document titled, Discharge Summary dated 6/12/2026 states in part, .Outpatient follow up with urology for foley exchanges every (6- 8 weeks). Foley exchanges should not be done at the SNF [Skilled Nursing Facility]. Consider suprapubic tube. if patient is retaining urine DO NOT exchange foley at SNF, and DO NOT overload [his/her] bladder with flushes. Also DO NOT use external abdominal pressure, this will NOT help with bladder decompression and increases risk for injury. Please reach out to urology or bring patient back to the hospital. Record review failed to reveal evidence that Resident ID #1 was scheduled for a Urology appointment as ordered from 4/28/2026 through 6/18/2026. During a surveyor interview on 6/18/2026 at 11:56 AM and 12:44 PM with the facility Scheduler, she revealed that Resident ID #1 had not been scheduled for a urologist appointment. Additionally, she revealed that she was able to make the resident's appointment today for 7/21/2026 after it was brought to the facility's attention by the surveyor. During a surveyor interview on 6/18/2026 at 12:00 PM with the Urology receptionist, she revealed that the facility had not contacted the urology office until today and the only referrals they had received for Resident ID #1 was from the hospital on 5/14/2026 and 6/12/2026. During a surveyor interview on 6/18/2026 at 1:26 PM with the PA, he revealed it would be his expectation that the facility would have scheduled a urology consult, per the physician's order on 4/28/2026 for an appointment, and was unaware that Resident ID #1 had not been seen by a urologist. The facility had multiple opportunities to ensure appropriate urologic follow-up, including after the physician's order dated 4/28/2026, following the resident's hospitalization for catheter-associated sepsis on 5/14/2026, after the PA documented the need for urology referral on 5/15/2026, and after the resident developed recurrent urinary symptoms including hematuria, abdominal distention, and a positive urinary tract infection. Despite these repeated indicators of worsening clinical condition, the facility failed to arrange the ordered consultation. 2. Record review revealed that Resident ID #2 was originally admitted to the facility in January of 2026 with a diagnosis including, but not limited to, flaccid neuropathic bladder (the inability of the bladder muscles to contract effectively leading to urinary retention). Review of a care plan dated 1/28/2026 revealed that Resident ID #2 requires an SP catheter related to neurogenic bladder. Interventions include but are not limited to changing the SP catheter per the physician's order. Record review revealed that the resident was admitted to the hospital from [DATE] to 5/14/2026 with a diagnosis of a complicated UTI and an obstructed SP catheter. Record review of a progress note authored by the PA dated 5/19/2026 states in part, .Patient had diminished output in [his/her] suprapubic catheter and then staff eventually unable to flush, sent to ED on 5/8/2026. Had replacement of his suprapubic catheter and continued to have some leakage around catheter site. Followed carefully by urology and recommended outpatient follow-up. Record review revealed a physician's order dated 6/8/2026 for his/her SP tube to be changed every 4 weeks. Record review of the 2026 June Treatment Administration Record revealed the above order was signed off as completed on 6/8/2026. During a surveyor interview on 6/18/2026 at 11:26 AM with the Assistant Director of Nursing Services, she revealed that the nurses do not change SP tubes in the facility. Additionally, she revealed that residents who require an SP tube exchange would go out to their urologist. During a surveyor interview on 6/18/2026 at 2:44 PM with Licensed Practical Nurse, Staff A, she revealed that she did not exchange Resident ID #2's SP tube. She further revealed that she signed off the above order in error and acknowledged that the resident needs to go to his/her urologist for a SP catheter exchange. During a surveyor interview on 6/18/2026 at 12:18 PM with Urology receptionist, she revealed that the last appointment Resident ID #2 had at their office for an SP catheter exchange was in July of 2025. She further revealed that s/he did not have an appointment scheduled at this time. During a surveyor interview on 6/18/2026 at 11:56 AM and 12:44 (continued on next page)		

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F 0690 Level of Harm - Actual harm Residents Affected - Few	PM with the facility Scheduler, she failed to reveal evidence that Resident ID #2 had a urology appointment until after it was brought to their attention by the surveyor. Additionally, she revealed that she was able to make the resident's appointment today for 7/10/2026. During a surveyor interview on 6/18/2026 at 1:26 PM with the PA, he revealed it would be his expectation that the facility would have scheduled a follow up appointment with urology for a SP tube exchange for Resident ID #2 every 4 weeks if it could not be completed in the facility. Record review failed to reveal evidence that Resident ID #2 has had a urology appointment or SP catheter exchange from his/her admission to the facility in January of 2026 until s/he was hospitalized in May of 2026 with a UTI and an obstructed SP catheter. Further record review failed to reveal evidence that the facility made a urology appointment from 5/8/2026 to 6/18/2026 until it was brought to the facility's attention by the surveyor.		