

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 03/26/2026
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, surveyor observation, and staff interview, the facility failed to store drugs and biologicals in accordance with currently accepted professional principles for 3 of 6 medication carts observed during the medication storage task. Findings are as follows: Record review of a facility policy titled, Medication Storage states in part, .medications will be stored in the original, labeled containers received from the pharmacy. Expired, discontinued and or/contaminated medications will be removed from the medication storage areas and disposed of in accordance with facility policy. 1a. During a surveyor observation on [DATE] at 9:15 AM of the second-floor medication cart side A in the presence of Registered Nurse (RN), Staff B, revealed the following: One 20 milliliter (mL) bottle of Lidocaine injection (a medication prescribed to prevent pain during a procedure), opened and undated. One tube of Erythromycin 0.5% (a medication prescribed to treat infection), opened and dated [DATE] with an expiration date of [DATE]. One 1.5 fluid ounce bottle of nasal moisturizing spray opened and dated [DATE] with no resident name identifier. During a surveyor interview immediately following the above observation, Staff B, acknowledged that the lidocaine was opened, undated and in use, the nasal spray should have a resident name identifier, and the Erythromycin should have been discarded. 1b. During a surveyor observation on [DATE] at 9:18 AM of the second floor nurse side A cart in the presence of Staff B, revealed the following: One 1-gram (gm) vial of Ceftriaxone (an antibiotic medication), with the prescription label partially torn off. Four 1-gram bottles of Ertapenem (an antibiotic medication) for two discharged residents. During a surveyor interview immediately following the above observation with Staff B, she acknowledged that the Ceftriaxone label did not contain the name of the resident for who it was prescribed and should have been discarded. Additionally, she acknowledged that the vials of Ertapenem were for residents who have been discharged and should have been discarded. 2. During a surveyor observation on [DATE] at 12:52 PM of the Third- floor medication Nurse cart Side A in the presence of, Licensed Practical Nurse, Staff C, revealed the following: One 1 gm vial of Ertapenem for a resident that was discharged .During a surveyor interview immediately following the above observation with Staff C, she acknowledged that the medication was prescribed for a resident who had been discharged and the medication should have been discarded. During a surveyor interview on [DATE] at 12:55 PM with the Director of Nursing Services, she revealed that it would be her expectation that nursing staff would remove expired or discontinued medications from the medication carts and dispose of them per the facility policy.</p>		

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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to maintain medical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented and readily accessible for 2 of 2 residents reviewed for physician referral outpatient appointments, Resident ID #s 10 and 104. Findings are as follows: 1. Record review revealed that Resident ID #10 was admitted to the facility in February of 2026 with diagnoses including, but not limited to, heart failure and a fall. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status score of 14 out of 15 indicating intact cognition. Record review of the hospital Discharge summary dated [DATE] revealed that the resident was admitted after s/he had a witnessed fall with a head injury. Further review revealed that s/he was scheduled to have a follow-up appointment within 2 weeks to discuss a hernia repair. Record review of nursing progress note dated 3/5/2026 states, ".Returned from general surgery with the following note, Dr. had to cancel clinic due to an emergency that came in. Appointment rescheduled [Communication] tab updated. Record review of the Communications Tab dated 3/5/2026 at 3:38 PM states, need transport: appointment rescheduled to 3/9/2026 at 1:45 PM. General Surgery. Record review failed to reveal evidence of a Continuity of Care (COC) report from the 3/5/2026 appointment. Further record review failed to reveal evidence that the resident went to a follow up appointment on 3/9/2026. During a surveyor interview with the general surgery office on 3/25/2026 at 1:30 PM, they revealed that the resident had an appointment on 3/16/2026 that s/he was a NO SHOW for. Additionally, the receptionist revealed that the resident was rescheduled again for April. During a surveyor interview with the Facility Scheduler, Staff D, on 3/25/2026 at 1:40 PM, she revealed that the nurses review the COC and add the follow-up appointments in the Communication Tab of the medical record. She further revealed she was not aware of the residents' follow-up appointment on 3/9 or 3/16/2026, indicating that transportation was not scheduled for this resident's appointment. During a surveyor interview on 3/25/2026 at 1:46 PM, with the Director of Nursing Services (DNS), she was unable to provide the COC document for Resident ID #10's appointment on 3/5/2026. She revealed that the scanning process for medical records is delayed and the COC could be in an office but could not locate the document. 2. Record review Resident ID #104 was admitted to the facility in January of 2026 with a diagnosis including, but not limited to, a left artificial hip joint. Record review of the MDS assessment dated [DATE], revealed a BIMS score of 15 out of 15, indicating the resident is cognitively intact. Record review of a nursing progress note dated 3/19/2026, revealed the resident had returned to the facility after an orthopedic appointment related to a failed total arthroplasty (joint replacement surgery). Additional review of the nursing progress note revealed that the resident needs dental clearance before the hip replacement surgery could be scheduled. Record review failed to reveal evidence of a COC report from the 3/19/2026 Orthopedic appointment. During a surveyor interview on 3/26/2026 at 1:13 PM, with the Orthopedics Administrator, she revealed that the resident was evaluated on 3/19/2026 related to a left hip replacement. The Physician documented several pre-operational instructions before the surgery would be scheduled. Additionally, she faxed the COC from the 3/19/2026 appointment to the surveyor. Record review of the COC, dated 3/19/2026 states in part, ".Clinical findings include severe pain and inability to ambulate. Imaging confirms upward migration of the acetabular component (movement of the hip replacement). which will continue to worsen without intervention. Patient instructions: Left hip replacement has failed and needs to be fixed with another surgery. Must see a dentist for a check-up and cleaning to make sure there are no infections. Will be referred to a bone health specialist and will need a bone density scan. Cardiac clearance required prior to surgery. Record review failed to reveal evidence that the above Orthopedic instructions provided on 3/19/2026 were implemented or reviewed with the provider. During a (continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>surveyor interview on 3/26/2026 at approximately 1:43 PM with the DNS, she could not provide the COC document for Resident ID # 104's orthopedic appointment on 3/19/2026. She revealed that the scanning process for medical records is delayed and the COC could be in an office but could not locate the document.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on clinical record review and staff interview, the facility failed to ensure residents maintain acceptable parameters of nutritional status, such as usual body weight relative to 1 of 1 resident reviewed for severe weight loss who was not reweighed for verification, Resident ID #8. Findings are as follows: Review of a facility policy titled, Weight Assessment and Interventions, dated 5/2019, states in part, "Weights will be recorded in the medical record (electronic health record where available) for each resident. Any weight change of 5lb [pounds] in a month and 3lbs in a week since their last weight assessment should be retaken within 72hrs for confirmation and verified by Nursing. Re weigh should be reviewed by the Licensed Nurse. Licensed Nurse should notify Dietician of identified weight change once reviewed. Dietician notification should be documented within Resident's medical record. Dietician should respond within 72 hours of receipt of notification. Review of the resident's record revealed s/he was readmitted to the facility in November of 2025 with diagnoses including, but not limited to, fractured left hip and dysphagia (difficulty swallowing). Record review revealed the following weight documentation: 1/5/2026 102.4 lbs. 2/5/2026 84 lbs. 2/17/2026 87 lbs. 2/23/2026 86.4 lbs. 3/2/2026 93.4 lbs. 3/9/2026 85.6 lbs. 3/16/2026 90.8 lbs. Additional record review revealed the resident experienced a severe weight loss of 18.4 lbs. in one month from 1/5/2026 to 2/5/2026. Record review failed to reveal evidence that the resident was re-weighed within 72 hours of 2/5/2026 to confirm and verify the current weight per the facility's policy. Additionally, record review failed to reveal evidence that the Registered Dietitian (RD) was notified of the severe weight loss until 2/17/2026, 12 days after his/her severe weight loss. Further record review failed to reveal evidence that the resident was reweighed per the facility policy after s/he experienced a weight gain of 7 lbs. from 2/23/2026 to 3/2/2026 and a weight loss of 7.8 lbs. from 3/2/2026 to 3/9/2026. During a surveyor interview with the RD on 3/25/2026 at 3:46 PM, she revealed that she is notified of residents' significant weight changes by the nursing staff and by running a report each month. She indicated that if there are weight discrepancies of 3 lbs. or more in a week or 5 lbs. or more in a month, then the resident is reweighed, usually on the same day. Additionally, she was unable to recall when she was notified of the resident's weight loss on 2/5/2026 and would have expected nursing staff to reweigh the resident per facility policy. Further, she indicated a reweight should have been obtained following the changes in the resident's weight on 3/2/2026 and 3/9/2026. During a surveyor interview with the Director of Nursing Services on 3/26/2026 at 1:34 PM, she indicated that if there is a significant change in a resident's weight, a reweigh should be completed within 24 hours by nursing staff. She indicated that if the change in weight is verified, she would expect nursing to notify the RD so she can assess the resident and implement interventions. Additionally, she acknowledged that reweighs were not obtained following the resident's severe weight loss on 2/5/2026 and his/her significant weight changes on 3/2/2026 and 3/9/2026, per the facility policy.</p>		

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<p>F 0838</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>Based on record review and staff interview, it has been determined that the facility assessment failed to include active involvement/input received from resident representatives, and family members. Findings are as follows: Record review of a facility provided document titled, Requirements of Participation: Facility Assessment, reviewed and approved on 1/21/2026, failed to reveal evidence that the facility developed and maintained a plan that included involvement by the residents' families and/or representatives. During a surveyor interview with the Director of Nursing Services on 3/26/2026 at 2:48 PM, she acknowledged that the facility assessment did not include input from resident representatives/families.</p>		