STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Dawn Hill Home for Rehab and Healthcare	One Dawn Hill Road Bristol, RI 02809

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on clinical record review, staff, and resident representative interview, the facility failed to immediately inform the resident's representative of a significant change in condition, which included an injury of unknown origin as the resident was found to have sustained fractures of his/her right ankle for 1 of 2 residents reviewed, Resident ID #1.Findings are as follows:Record review of a community reported complaint submitted to the Rhode Island Department of Health, on 3/19/2026 alleged that the resident's representative was not informed of an injury the resident sustained and the possible cause.Review of the facility's policy dated 10/19/2023 and titled Notification of Change in Resident's Condition states in part, .responsible family members or legal representatives shall be notified as soon as possible, or within 24 hours, of any changes in the resident's condition. The nurse on duty shall be responsible for notifying the resident's responsible family members when a change occurs.these changes shall include significant changes in physical.as well as any accidents that results in injury. The nurse on duty shall document this notification on the resident's medical record.Record review revealed the resident was admitted to the facility in October of 2025 with a diagnosis including, but not limited to, Alzheimer's disease. The resident was admitted to the facility while receiving and continues to receive hospice services (a specialized care for individuals with a terminal illness who are approaching the end of life). Record review of a progress note authored by Registered Nurse, Staff A dated 3/9/2026 at 2:40 PM, revealed the resident was observed to be grimacing after being brought to the dining room. Further assessment identified the resident's right ankle to be swollen and bruised. An order was obtained for an x-ray of the right ankle and foot.Record review of an x-ray report dated 3/9/2026 at 11:33 PM, confirmed an acute to subacute fractures of the medial malleolus with displacement and a moderately displaced fracture of the lateral malleolus.Record review of a progress note dated 3/10/2026 at 12:15 AM authored by Nurse Practitioner, Staff B revealed the x-ray results showed an acute to subacute fracture of his/her medial malleolus (an inner ankle bone) and a moderately displaced fracture of his/her lateral malleolus (an outer ankle bone). Additionally, the progress note revealed an order to contact hospice and the resident's representative to review the findings.Record review failed to reveal evidence that the resident's representative was notified by the facility of the resident's injuries.During a surveyor interview on 3/24/2026 at 11:20 AM, with the resident's representative, s/he revealed that s/he was not notified by the facility of the resident's injuries. S/he stated that the hospice staff informed him/her of the injuries.During a surveyor interview with Staff A on 3/24/2026 at 1:24 PM, she acknowledged that she was the nurse on duty when the bruising and swelling to the resident's right foot were identified. She further acknowledged that she did not notify the resident's representative of the injuries.During surveyor interviews on 3/24/2026 at 12:07 PM and at 1:58 PM with the Director of Nursing Services, she was unable to provide evidence that the resident's representative was immediately notified of the resident's injuries when they were identified by the staff.Cross reference F-609 and F-610

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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NAME OF PROVIDER OR SUPPLIER The Dawn Hill Home for Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE One Dawn Hill Road Bristol, RI 02809	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to ensure that all alleged violations including injuries of unknown origin, were reported to the Rhode Island Department of Health (RIDOH) immediately, but not later than 2 hours after the injuries were identified, for 1 of 1 resident reviewed who sustained an injury of unknown origin, Resident ID #1. Findings are as follows:Record review of a community reported complaint submitted to RIDOH on 3/19/2026 alleged that Resident ID #1 sustained an injury of unknown origin and that the resident's family was not notified by the facility at the time of the discovery. The complainant reported that notification was received from the hospice agency.Record review revealed that the resident was admitted to the facility in October of 2025 with a diagnosis including, but not limited to, Alzheimer's disease. The resident was admitted on and continues to receive hospice services (a specialized care for individuals with a terminal illness and are approaching the end of life). Record review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident is non-ambulatory (a person who is unable to walk) and is dependent on staff for all transfers. Review of a Brief Interview for Mental Status Assessment revealed the resident has severe cognitive impairment.Record review of a progress note authored by Registered Nurse, Staff A, dated 3/9/2026 at 2:40 PM, revealed the resident was grimacing after being brought to the dining room by the staff, and was found to have swelling and bruising to the right ankle. An order was obtained for an x-ray of the right foot and ankle.Record review of an x-ray report dated 3/9/2026 at 11:33 PM confirmed an acute to subacute fractures of the medial malleolus (the inner ankle) with displacement and a moderately displaced fracture of the lateral malleolus (the outer ankle).Record review of a progress note dated 3/10/2026 at 12:15 AM authored by Nurse Practitioner, Staff B, revealed the x-ray results showed an acute to subacute fracture of the medial malleolus and an acute to subacute moderately displaced fracture of the lateral malleolus. Additionally, the progress note revealed an order to contact hospice and the resident's representative to review the findings.Record review failed to reveal evidence that the cause of the injury was identified in the resident's record, which indicates this is an injury of unknown origin. Additional record review failed to reveal evidence that the injury of unknown origin was reported to the Rhode Island Department of Health.During a surveyor interview on 3/24/2026 at 12:24 PM with a hospice aide, Staff C, she stated that she had taken the resident into his/her room after lunch to provide care, accompanied by two of the facility's staff who, Nursing Assistants, Staff D and Staff E. Staff C stated that the resident did not exhibit discomfort prior to care; however, during care, the resident became agitated and flailed his/her upper and lower extremities. She stated that Staff D held down the resident's legs and Staff E held down the resident's arms while care was completed. Staff C acknowledged she did not stop care when the resident became agitated and did not notify the nurse on duty of the resident's behavior. She stated that after care was provided, the resident was transferred to the chair and taken back to the dining room. Staff C stated that she left the unit for her lunch break and upon her return, she learned the resident had a swollen ankle. She stated she did not know how the injury occurred.During a surveyor interview on 3/24/2026 at 1:24 PM, with Registered Nurse, Staff A, she acknowledged that she was the nurse on duty when the resident's injury was identified and was unable to provide evidence that the injury of unknown origin was reported to RIDOH.During surveyor interviews on 3/24/2026 at 12:07 PM and 1:58 PM, with the Director of Nursing Services (DNS), she acknowledged that the facility did not report the injury of unknown origin to RIDOH. Cross reference F-580 and F-610

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure that an injury of unknown origin was thoroughly investigated for 1 of 1 resident reviewed who sustained fractures to his/her right ankle, Resident ID #1. Findings are as follows:Record review of a community-reported complaint submitted to the Rhode Island Department of Health on 3/19/2026 alleged that the resident sustained an injury of unknown origin and that the resident's representative was not informed of the injury or the possible cause.Record review revealed the resident was admitted to the facility in October of 2025 with a diagnosis including, but not limited to, Alzheimer's disease. The resident was admitted to the facility while receiving and continues to receive hospice services (a specialized care for individuals with a terminal illness who are approaching the end of life). Record review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident is non-ambulatory (a person who is unable to walk) and is dependent on staff for all transfers. Review of a Brief Interview for Mental Status Assessment revealed the resident have severe cognitive impairment.Record review of a progress note authored by Registered Nurse (RN), Staff A, dated 3/9/2026 at 2:40 PM, revealed the resident exhibited grimacing after being brought to the dining room by the staff. Further review of the notes revealed the resident was found to have swelling and bruising to his/her right ankle. An order was obtained for an x-ray of the right foot and ankle.Record review of an x-ray report dated 3/9/2026 at 11:33 PM confirmed an acute to subacute fractures of the medial malleolus with displacement and a moderately displaced fracture of the lateral malleolus.Record review failed to reveal evidence that the facility conducted a thorough investigation into the circumstances surrounding the resident's injury. Furthermore the record lacked documentation by the provider or staff determining potential causes of the injury or the identification of cause of the injuries. Additional record review failed to reveal evidence that the facility implemented interventions to prevent further/potential injuries to the resident.Record review of a progress note authored by Nurse Practitioner, Staff B, dated 3/10/2026 at 12:15 AM, revealed that the X-ray results identified an acute to subacute fracture of the medial malleolus (the inner ankle) and an acute to subacute moderately displaced fracture of the lateral malleolus (the outer ankle).During a surveyor interview on 3/24/2026 at 12:24 PM with hospice aide, Staff C, she stated that she had taken the resident into his/her room after lunch to provide care accompanied by two facility staff, Nursing Assistants, Staff D and Staff E. Staff C stated that the resident did not exhibit discomfort prior to care; however, during care, the resident became agitated and flailed his/her upper and lower extremities. She stated that Staff D held down the resident's legs and Staff E held down the resident's arms while care was completed. Staff C acknowledged she did not stop care when the resident became agitated and did not notify the nurse on duty of the resident's behavior. She stated that after care was provided, the resident was transferred to a chair and was taken back to the dining room. Staff C stated that she left the unit for her lunch break and upon her return, she learned the resident had a swollen ankle. She stated she did not know how the injury occurred.During an interview on 3/24/2026 at 1:24 PM, RN, Staff A, she acknowledged that she was the nurse on duty when the resident's right ankle was observed to be swollen and bruised. She revealed that she had called the provider and informed them of the injury that was observed and obtained the order for x-rays. Additionally, she was unable to provide evidence that an investigation into the origin of the injuries had been conducted.During surveyor interviews on 3/24/2026 at 12:07 PM and at 1:58 PM, with the Director of Nursing Services, she was unable to provide evidence that a thorough investigation was conducted, that measures were implemented to prevent further potential injury, or that investigative findings were reported in accordance with regulatory requirements.During a surveyor interview on 3/24/2026 at 2:05 PM with Nurse Practitioner, Staff F, she revealed that she was made aware of the resident's injury and had ordered an x-ray which confirmed the fractures. Staff F indicated that she was made aware the resident had exhibited (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behaviors during care; however, she could not definitively determine the origin of the injuries. Lastly, Staff F acknowledged that there was no documentation in the resident's record that established the origin of the injuries.Cross reference F-580 and F-609