STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415050	A. Building B. Wing	06/04/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 an indwelling foley catheter (a flexible tube that collects urine from the bladder and empties the urine into a drainage bag), Resident ID #14.Findings are as follows:Record review revealed the resident was admitted to the facility in January of 2026 with diagnoses including, but not limited to, obstructive uropathy (a structural or functional hindrance of normal urine flow) and urinary retention.Record review of a hospital discharge document titled, Discharge summary dated [DATE] revealed the resident was treated for a catheter associated urinary tract infection with an order for a urology follow-up and consideration of a Transurethral Resection of the Prostate (TURP, a surgical procedure to remove excess prostate tissue through the urethra to relieve urinary problems).Record review revealed that the resident's hospital Discharge summary, dated [DATE] revealed the resident was treated for a catheter associated urinary tract infection with an order which states, .already have urology referral from previous discharge .Review of a physician progress note dated 4/5/2026 revealed that the resident was assessed related to his/her recent admission to the hospital with a diagnosis of encephalopathy (abnormal brain function, leading to altered mental states and cognitive impairment) due to a urinary tract infection and a urology referral was ordered.Record review revealed the following Nurse Practitioner notes:4/8/2026 revealed the resident was seen by the provider for an acute visit which states in part, .being started on Bactrim DS (an antibiotic) orally twice daily for 5 days for urinary tract infection.***follow-up***.Urology referral pending.4/15/2026 revealed the resident has a urology appointment scheduled for this morning.Record review failed to reveal evidence that the resident went to his/her urology appointment on 4/15/2026.Review of a nursing progress note dated 4/17/2026 revealed that the resident had a urology appointment rescheduled for 5/5/2026.Review of a nursing progress note dated 5/5/2026 revealed that the resident was unable to be seen by the Urologist and an appointment needs to be rescheduled in the morning.Record review revealed the following Nurse Practitioner notes:5/8/2026 states in part, .Reschedule urology outpatient appointment (canceled this week) .5/11/2026 states in part, .Urology outpatient appointment needs to be scheduled.5/19/2026 states in part, .Urology outpatient appointment still needs to be scheduled. 5/29/2026 states in part .Urology outpatient appointment still needs to be scheduled.***follow-up***.Urology outpatient appointment - needs to be scheduled.During a surveyor interview on 6/3/2026 at 9:09 AM with the Facility Scheduler, she revealed that the resident's urology appointment had not been scheduled. Review of a nursing progress note dated 6/3/2026 at 10:57 AM, revealed that the resident has a urology appointment scheduled for 6/10/2026 at 9:30 AM scheduled after it was brought to the facility's attention by the surveyor.During a surveyor interview on 6/3/2026 at 1:16 PM, with the Director of Nursing Services, she revealed that she would have expected the resident's urology appointment to be rescheduled immediately after the 5/5/2026 appointment was canceled.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415050	A. Building B. Wing	06/04/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure that services were provided in accordance with professional standards of quality by failing to implement and follow physician orders. Specifically, the facility failed to follow a physician's order for a cancer center referral for 1 of 1 resident reviewed, Resident ID #102, and failed to appropriately manage and follow physician orders related to a peripherally inserted central catheter (PICC) line-a thin, flexible tube inserted into a peripheral vein in the upper arm and advanced to a large central vein near the heart-for 1 of 1 resident reviewed with a PICC line, Resident ID #138. Findings are as follows:1. According to Mosby's 4th Edition, Fundamentals of Nursing page 314, which states in part, 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.Record review revealed Resident ID #102 was admitted to the facility in August of 2022 with diagnoses including, but not limited to, dementia and chronic kidney disease.Review of the quarterly Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 3 out of 15, indicating severe cognitive impairment.Review of a skin assessment dated [DATE] revealed an inverted nipple and drainage of the left breast.Record review revealed the following Nurse Practitioner notes:5/19/2026- a left-sided inverted nipple with drainage noted on the inside with a pea-sized nodule at approximately the 3 o'clock position of the left breast. An ultrasound of the area was ordered.5/20/2026- ultrasound of the left breast completed with results confirming a nodule measuring 4 millimeters (mm) by 4 mm by 3 mm in the 3 o'clock position. Goals of care were discussed with the resident's family member and a consult with the cancer center for further evaluation and treatment was ordered. The facility is to schedule and arrange for transport. Record review revealed a physician's order dated 5/20/2026 for a breast consultation.Record review failed to reveal evidence that an appointment with the cancer center was scheduled or completed as ordered. During a surveyor interview on 6/2/2026 at approximately 1:15 PM with the South Unit Manager, Staff B, she acknowledged that the resident had not followed up with the cancer center and that an appointment had not been scheduled.During a surveyor interview on 6/2/2026 at 1:18 PM with the scheduler, she acknowledged that she received the physician's order to schedule the cancer center appointment on 5/20/2026; however, she did not schedule the appointment for the resident.During a surveyor interview on 6/3/2026 at 1:38 PM with the Director of Nursing Services (DNS), she revealed that she would have expected the cancer center appointment to have been scheduled as ordered as soon as possible.2. Review of the facility policy titled, Vascular Access Devices and Infusion Therapy Procedures Peripherally Inserted Central Line Catheter (PICC) dated 10/24, states in part, .measure arm circumference of upper arm.on admission as a baseline.10 cm (centimeters) above the insertion site.Measure external length of PICC catheter.on admission, with each dressing change, and when clinically indicated.Record review revealed Resident ID #138 was admitted to the facility in May of 2026 with diagnoses including, but not limited to, pneumonitis (a condition characterized by swelling and irritation of the lung tissue) and surgical aftercare following surgery on the digestive system.Review of the PICC Insertion Record dated 5/23/2026 revealed the PICC line was inserted on 5/23/2026 into the right arm with an external length of 0. Further review revealed the resident's arm circumference measured 25 cm.Review of the NSG Admission/readmission Evaluation (RI and NH) - V2 dated 5/27/2026 failed to reveal evidence that the PICC line was noted, assessed, or that the resident's arm circumference and external catheter length was measured. Record review failed to reveal evidence that a care plan was in place pertaining to PICC line care.Record review of the progress notes revealed the resident's PICC line dressing was changed on 5/28/2026. Further review failed to reveal evidence that the resident's arm circumference measurement was obtained. During a surveyor observation on 6/3/2026 at 1:29 PM, the resident's PICC line dressing was intact and dated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415050	A. Building B. Wing	06/04/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/1/26.Record review failed to reveal documentation that the PICC line dressing had been changed on 6/1/2026, measurement of the external catheter length, or measurement of the resident's arm circumference was obtained, until after it was brought to the facility's attention by the surveyor on 6/3/2026.During a surveyor interview on 6/3/2026 at 11:14 AM with North Wing Manager, Staff A, she revealed that the PICC line external catheter length should be measured when the dressing is changed. During a surveyor interview on 6/3/2026 at 12:58 PM with East Unit Manager, Staff C, she revealed that she changed the resident's PICC line dressing on 6/1/2026 due to the edges of the dressing lifting. Additionally, she revealed that she did not receive a physician's order or document the dressing change, the external catheter length, or the resident's arm circumference measurement until 6/3/2026 at 12:24 PM. This documentation was entered into the electronic medical record 2 days after the dressing change and after the surveyor interviewed staff regarding concerns with Resident ID #138's PICC line assessments and documentation. During a surveyor interview on 6/3/2026 at 1:42 PM with the DNS, she revealed that she would expect the PICC line external catheter length and the arm circumference measurements to be obtained and documented on admission and when dressing changes are completed. She further revealed that she would expect nursing notes to be completed timely, usually prior to the end of the nurse's shift. Additionally, she revealed that she would expect a care plan to be in place pertaining to the PICC line.Record review revealed late entry progress notes were entered into the electronic medical record on 6/3/2026 to include PICC line external measurements and arm circumference measurements, after it was brought to the facility's attention by the surveyor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415050	A. Building B. Wing	06/04/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure each resident's medication regimen is free from a medication error rate of 5% or greater. Based on 26 opportunities for error observed during the medication administration task, there were 2 errors resulting in an error rate of 7.69% affecting Resident ID #s 51 and 75.Findings are as follows:Review of a facility policy titled, Medication Administration General Guidelines dated February 2026, states in part, .Medication Preparation: Prior to administration, review and confirm medication orders for each individual client on the Medication Administration Record (MAR). Compare the medication and dosage schedule on the client's MAR with the medication label.Medications are administered in accordance with written orders of the prescriber.1. Record review revealed Resident ID #75 has a physician's order for Miralax (a medication prescribed to treat constipation) oral powder 17 Gram two times a day, dilute with at least 4 ounces (oz) of fluid.During a surveyor observation during the medication administration task on 6/2/2026 at 9:00 AM with Certified Medication Technician (CMT), Staff D, she was observed diluting the resident's Miralax in a 7 oz cup that was filled at approximately 1/3 of the cup (approximately 3 oz) with water, without measuring the water prior to diluting the Miralax. Staff D attempted to administer the medication to the resident before being stopped by the surveyor.During a surveyor interview immediately following the above-mentioned observation, she acknowledged that she did not dilute the Miralax in the required amount of fluids, as ordered. Additionally, Staff D stated that she was unsure of how to measure the 4 oz of fluids that was ordered. 2. Record review revealed Resident ID #51 has a physician's order for Senna Plus (a medication prescribed to treat constipation) 8.6-50 milligram, give two tablets by mouth daily. During a surveyor observation during the medication administration task on 6/2/2026 at 9:09 AM with CMT, Staff E, she was observed administering one tablet of Senna Plus instead of two tablets, as ordered.During a surveyor interview immediately following the above-mentioned observation, she acknowledged that she administered one tablet instead of two, as ordered.During a surveyor interview on 6/3/2026 at 2:32 PM with the DNS, she indicated that she would expect the staff to follow all physician's orders including all instructions when administering medications to the residents.