

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Pawtucket Falls Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 70 Gill Ave Pawtucket, RI 02861	
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and staff interview, the facility failed to ensure that the comprehensive care plan was revised by the interdisciplinary team after changes of condition for 5 of 6 residents reviewed, Resident ID #s 1, 3, 4, 5, and 6. Findings are as follows: Record review of a Facility policy titled, Care Plan Revisions Upon Status Change revealed in part, The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. The MDS coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options. The care plan will be updated with the new or modified interventions. 1. Review of a facility reported incident submitted to the Rhode Island Department of Health on 7/8/2026, revealed in part, that on 7/8/2026 Resident ID #6 slapped Resident ID #1 on the shoulder. 1a. Record review revealed Resident ID #1 was admitted to the facility in January of 2026 with diagnoses which include, but are not limited to, dementia with agitation and depression. Record review of a care plan dated 6/8/2026 revealed that the resident has the potential to be physically aggressive and combative. This care plan was updated on 7/9/2026 to include that on 7/8/2026 there was a resident-to-resident incident, where Resident ID #1 was originally the victim, but retaliated and became the aggressor. Further record review of the care plan failed to reveal evidence that the care plan was revised to include the addition of new interventions after the 7/8/2026 incident. 1b. Record review revealed Resident ID #6 was admitted to the facility in June of 2026 with diagnosis including, but not limited to, dementia with agitation. Record review of a care plan dated 1/7/2026 revealed that the resident is verbally and physically aggressive to others, difficult to redirect, and refuses medications and care. This care plan was updated on 7/9/2026 to include that on 7/8/2026 there was a resident-to-resident incident, and Resident ID #6 was the aggressor. Further record review of the care plan failed to reveal evidence that the care plan was revised to include the addition of new interventions after the 7/8/2026 incident. 2. Review of a facility reported incident submitted to the Rhode Island Department of Health on 6/23/2026, revealed in part, that on 6/23/2026 Resident ID #3 arm was grabbed by another resident who attempted to drag him/her out of his/her room. Record review revealed Resident ID #3's was admitted to the facility in June of 2026 with diagnoses including, but not limited to, dementia with behavioral disturbance and adjustment disorder. Record review of a care plan dated 6/8/2026 revealed that the resident has the potential to be physically/verbally aggressive. This care plan was updated on 7/16/2026 to include that on 6/23/2026 there was a resident-to-resident incident, and Resident ID #3 was the victim. Further record review of the care plan failed to reveal evidence that the care plan was revised to include the addition of new interventions after the 6/23/2026 incident. 3. Review of a facility reported incident submitted to the Rhode Island Department of Health on 6/23/2026, revealed in part, that on 6/23/2026 Resident ID #4 had another resident attempt to pull him/her out of his/her room in an (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
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Pawtucket Falls Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 70 Gill Ave Pawtucket, RI 02861	
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	aggressive manor. The facility reported incident further revealed that the same resident also attempted to pull Resident ID #5 out of his/her room in an aggressive manner.3a. Record review revealed Resident ID #4 was admitted to the facility in April of 2026 with diagnoses including, but not limited to, dementia, generalized anxiety, and adjustment disorder.Record review failed to reveal evidence that the resident's care plan was revised to include the resident-to-resident incident that took place on 6/23/2026, where s/he was the victim, or new interventions to prevent further incidents.3b. Record review revealed Resident ID #5 was admitted to the facility in November of 2022 with diagnoses including, but not limited to, dementia, major depressive disorder, and adjustment disorder.Record review failed to reveal evidence that the resident's care plan was revised to include the resident-to-resident incident that took place on 6/23/2026, where s/he was the victim, or new interventions to prevent further incidents.During a surveyor interview on 7/16/2026 at 1:54 PM with Licensed Practical Nurse, Staff A, she revealed that the care plan should have been revised with new interventions after the above incidents. She acknowledged that the care plans for Resident ID #s 1, 3, 4, 5, and 6 failed to be revised with new interventions.During a surveyor interview on 7/17/2026 at approximately 2:30 PM, the Director of Nursing Services acknowledged that the care plans for Resident ID #s 1, 3, 4, 5, and 6 failed to be revised, with new interventions after the above resident-to-resident incidents.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Pawtucket Falls Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 70 Gill Ave Pawtucket, RI 02861	
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 - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and staff interview, the facility failed to meet professional standards of quality relative to not following physician's orders for behavior monitoring for 2 of 4 resident's reviewed, Resident ID #s 2 and 6. Findings are as follows: According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 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 client. 1. Record review revealed Resident ID #2 was admitted to the facility in April of 2026 with diagnoses which included, but were not limited to, Alzheimer's Disease and anxiety disorder. Record review revealed a physician's order, dated 4/15/2026 to monitor the resident's mood, behavior and agitation every shift. It contains instructions to document the number of occurrences and the interventions utilized. Record review of the June 2026 Medication Administration Record (MAR) failed to reveal documentation of the number of occurrences or the interventions utilized. Further review of the resident's record failed to reveal that the resident's mood, behavior and agitation, including the number of occurrences and interventions utilized, were being documented every shift, as per the physician's order. 2. Record review revealed Resident ID #6 was admitted to the facility in June of 2026 with diagnosis which included, but were not limited to, dementia with agitation. Record review revealed a physician's order, dated 4/3/2026 to monitor the resident's mood, behavior, and agitation every shift. It contains instructions to document the number of occurrences and the interventions utilized. Record review of the July 2026 MAR failed to reveal documentation of the number of occurrences or the interventions utilized. Further review of the resident's record failed to reveal that the resident's mood, behavior and agitation, including the number of occurrences and interventions utilized, were being documented every shift, as per the physician's order. During a surveyor interview on 7/16/2026 at approximately 2:30 PM with the Director of Nursing Services, she could not provide evidence that Resident ID #s 2 and 6 had behavior monitoring related to mood, behavior, or anxiety, including the number of occurrences and interventions utilized, every shift per the physician's order.		