STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415075	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holiday Retirement Home Inc	30 Sayles Hill Road Manville, RI 02838

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on clinical record review and staff interview, the facility failed to ensure that a resident with an injury of unknown origin was thoroughly investigated for 1 of 1 resident reviewed for bruising, Resident ID #3.Findings are as follows:Review of a facility policy titled, Abuse prohibition states in part, .Injuries of unknown origin .the source of the injury was not observed, or the source cannot be explained by the resident .Investigation .begin the initial investigation .obtain statements from witnesses, notify the appropriate administrative personnel so that a comprehensive internal facility investigation can be carried out .Record review revealed the resident was readmitted to the facility in July of 2025, with diagnoses including, but not limited to, chronic inflammatory demyelinating polyneuropathy (an autoimmune disorder that affects the protective layer surrounding peripheral nerves) and lymphedema (an accumulation of protein rich fluid in the body's tissues).Record review of the progress notes revealed the following:-8/26/2025 at 7:26 PM a large bruise was noted to right upper buttock-9/8/2025 at 6:22 AM during care at 12 AM, staff found a large bruise on his/her left proximal thigh area which was deep purple in color and measures approximately 18 centimeters (cm) by 22 cm.Further record review failed to reveal evidence that an investigation had been conducted to determine the origin of the bruises.During a surveyor interview on 12/23/2025 at approximately 2:30 PM with the Director of Nursing Services, he indicated when new bruising is identified an investigation should be completed to determine the etiology of the bruising. It then should be documented in the resident's clinical record. Additionally, he was unable to provide evidence that an investigation was completed to determine the etiology of the bruising documented on 8/26/2025 and 9/8/2025.

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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(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. Based on clinical record review and staff interview, the facility failed to ensure that residents receive care, consistent with professional standards of practice relative to physician's orders, for 1 of 1 resident who requires two staff members at all times during care, Resident ID #3 and for 1 of 1 resident who requires a cardiology consult, Resident ID #1.Findings are as follows:Review of a facility reported incident submitted to the Rhode Island Department of Health on 8/28/2025 revealed in part, on 8/27/2025 Resident ID #3 was taken to the shower room and a hospice Nursing Assistant (NA) attended to him/her for his/her shower. During the shower the resident was noted with active bleeding from an unidentified source. A skin assessment was completed, and the resident was observed with an open area to his/her great toe.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 that the orders are in error or would harm the clients.Record review revealed the resident was readmitted to the facility in July of 2025, with diagnoses including, but not limited to, chronic inflammatory demyelinating polyneuropathy (an autoimmune disorder that affects the protective layer surrounding peripheral nerves) and lymphedema (an accumulation of protein rich fluid in the body's tissues).Record review revealed a physician's order dated 7/10/2025, for two staff members at all times for resident care.Record review revealed the following progress notes:-8/27/2025 at 10:14 AM- During the resident's shower, the Nursing Assistant, (NA) observed active bleeding but was unable to identify the source. Upon nursing arrival, a pool of blood was noted in the bathroom. A skin assessment revealed and open area to the top of the right great toe with a split to the skin. Initial pressure was applied for approximately 20 minutes, but the bleeding persisted.-8/27/2025 at 9:03 PM- traumatic wound to right great distal tip of great toe 0.3 centimeters (cm) by 0.5 cm by 0.1 cm, copious amount of blood drainage on dressing and active bleeding noted when the dressing was removedDuring a surveyor interview with NA, Staff A, she indicated that she was assigned to the resident on 8/27/2025 during the 7:00 AM to 3:00 PM shift. Additionally, she revealed she assisted the resident into the shower chair via the Hoyer lift (a mechanical device used to support the resident with transferring) along with the hospice, NA. Further, she indicated that she was not aware that the resident required two staff members for care at all times and revealed that the hospice aid showered the resident alone.Record review failed to reveal evidence that the resident was provided two staff members at all times for care during his/her shower on 8/27/2025 during the 7:00 AM to 3:00 PM shift as ordered.2. Record review revealed Resident ID #1 was readmitted to the facility in September of 2025 with diagnoses including, but not limited to, myocardial infarction (a heart attack) and cerebral infarction (a stroke).Record review revealed the following physician's orders: -3/21/2025 Aspirin 81 milligrams (mg) daily -3/21/2025 Plavix (a medication used to thin the blood) 75 mg dailyRecord review of a progress notes dated 10/30/2025 revealed the resident is on a dual antiplatelet therapy of aspirin and Plavix. The pharmacy has recommended discontinuation of the Plavix. This recommendation was reported to the physician with a new order received to consult with a cardiologist prior to the discontinuation of the medication. Additional record review revealed a physician's order dated 10/31/2025 to obtain a cardiology consult per the Physician for possible discontinuation of Plavix. Record review failed to reveal evidence that a cardiology consult had been scheduled as ordered.During a surveyor interview on 12/23/2025 at 1:22 PM with the Scheduler, Staff B, she indicated she was unaware that the resident needed an appointment with cardiology, and she had not reached out to schedule an appointment for the resident.During a surveyor interview on 12/23/2025 at 2:59 PM with the Director of Nursing Services, he revealed it would be his expectation that two (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff members would have been present as ordered during the shower provided to Resident ID #3 on 8/27/2025 and that the cardiology appointment would have been scheduled for Resident ID #1 per the physician's order.