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	05/08/2026

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 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 interview, the facility failed to ensure that an allegation involving an accident resulting in serious injury, which occurred prior to a resident's death, was reported to the appropriate authorities, including the State Survey Agency, as required by State law, for 1 of 1 resident reviewed Resident ID #1.Findings are as follows:Record review of a community-reported complaint submitted to the Rhode Island Department of Health on [DATE] alleged that Resident ID #1 sustained a fall with a head injury. The complaint further alleged that the resident expired approximately six hours after his/her fall.Record review revealed that Resident ID #1 was readmitted to the facility in October of 2025 with diagnoses including, but not limited to, acute respiratory failure with hypoxia (a condition where the tissues and cells of the body do not receive enough oxygen to function properly) and heart failure.Record review of a progress note dated, [DATE] at 7:02 PM, authored by Licensed Practical Nurse, Staff D, revealed the resident sustained an unwitnessed fall and was lying face down on the floor. The note further documented active bleeding from the resident's nose and forehead following the fall.Further record review of a hospice visit note dated [DATE] at 7:50 PM documenting that the resident was evaluated by hospice nursing staff secondary to the unwitnessed fall with head injury. Upon assessment, the resident was noted to have a hematoma (a collection of clotted blood between the tissues) and a laceration to the forehead.Record review failed to reveal evidence that the facility reported the death to the appropriate authorities, including the State Survey Agency, in accordance with state law through established procedures.Record review revealed the resident expired on [DATE] at 1:15 AM.During a surveyor interview on [DATE] at 1:03 PM with the Director of Nursing Services, he acknowledged that the resident sustained a head injury as a result of the fall on [DATE] prior to his/her death. Additionally, he was unable to provide evidence that the facility reported the death to the appropriate authorities, including the State Survey Agency, in accordance with state law through established procedures.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 clinical record review and staff interview, the facility failed to ensure each resident's care plan is revised by the interdisciplinary team, for 1 of 2 residents reviewed relative to falls, Resident ID #2.Findings are as follows:Record review of a facility reported incident submitted to the Rhode Island Department of Health on 4/3/2026 revealed Resident ID #2 had a fall on 3/30/2026 and was subsequently diagnosed with a left wrist fracture.Record review revealed Resident ID #2 was admitted to the facility in July of 2025 with diagnoses including, but not limited to, Alzheimer's disease and a history of falls. Record review revealed Resident ID #2 sustained falls on 3/29/2026 and 3/30/2026.Further record review revealed the resident was transferred to the hospital following the 3/30/2026 fall and was subsequently diagnosed with a left wrist fracture. Additional record review revealed that on 4/4/2026, the resident was diagnosed with a left hip fracture.Record review of the resident's care plan revealed a problem area initiated on 3/25/2026 addressing the resident's increased risk for injury related to impaired balance, history of falls, and cognitive impairment. Further review of the care plan failed to reveal evidence that interventions were revised or updated following the 3/29/2026 and 3/30/2026 falls to address the resident's ongoing risk for injury. During a surveyor interview on 5/8/2026 at 1:03 PM with the Director of Nursing Services, he was unable to provide evidence that the resident's care plan was revised or updated with additional interventions following the above-referenced falls.

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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 treatment and services in accordance with professional standards of practice and physician orders, relative to the transcription and implementation of physician-approved hospice medication orders, 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 5/5/2026 alleged that Resident ID #1 was experiencing terminal agitation and was not provided prescribed medications promptly to provide comfort, relief, and dignity at the end of his/her life.According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, 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 #1 was readmitted to the facility in October of 2025 with diagnoses, including, but not limited to, acute respiratory failure with hypoxia (a condition where the tissues and cells of the body do not receive enough oxygen to function properly) and heart failure. Further review revealed the resident was admitted to hospice services on 5/1/2026. 1. Record review revealed a hospice note dated 5/1/2026 with a recommendation to start levsin (a medication prescribed to treat excessive salivation) 0.125 milligram (mg) tablet under the tongue every four hours, as needed, for secretions.Further record review of a progress note dated 5/2/2026 at 12:14 PM revealed the provider approved the order for levsin.Record review failed to reveal evidence that the physician-approved order was transcribed into the medical record or implemented by facility staff.During a surveyor interview on 5/7/2026 at 3:48 PM with the Assistant Director of Nursing Services, she acknowledged that the levsin order had not been transcribed into the medical record and should have been implemented, as ordered. 2. Record review of a hospice note dated 5/3/2026 revealed recommendations including, but not limited to: - Lorezapam intensol (a medication prescribed to treat restlessness and agitation) two mg per milliliter (ml); 1mg (0.5ml), as needed for agitation and restlessness. - Morphine Concentrate 20mg/ml; 10 mg (0.5ml) every one hour, as needed for pain or shortness of breathRecord review of a progress note dated 5/3/2026 at 9:47 PM revealed the provider approved the above recommendations.Record review revealed the following physician's orders were incorrectly transcribed on 5/3/2026: - Lorezapam intensol two milligrams (mg) per milliliter (ml) give 1mg (0.5ml), scheduled for every one hour - Morphine Concentrate 20mg/ml give 10 mg (0.5ml), scheduled for every one hourFurther review of the May 2026 Medication Administration Record (MAR) revealed that the above medications were administered on 5/4/2026 at 12:00 PM as scheduled medications, rather than on an as-needed basis, as ordered, by the physician. During a surveyor interview on 5/7/2026 at 4:19 PM, Registered Nurse, Staff F, acknowledged that she incorrectly transcribed the Lorazepam and Morphine orders as scheduled medications instead of as-needed medications, per the physician's orders.During a surveyor interview on 5/8/2026 at 2:24 PM, with the Physician, Staff E, he acknowledged that the levsin order had been approved and should have been transcribed. He further acknowledged that the Morphine and Lorazepam orders had been approved as needed orders, not as scheduled medications as transcribed by facility staff.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure residents receive care and services in accordance with professional standards of practice related to post-fall assessments, neurological monitoring, care plan revision, and adherence to advance directives, for 1 of 1 resident who sustained a fall with head injury, Resident ID #1.Findings are as follows:Review of a community reported complaint received by the Rhode Island Department of Health on [DATE], alleged that Resident ID #1 experienced a fall with a head injury and passed away in the facility within 6 hours. The complaint further alleged that the facility failed to implement new or enhanced fall interventions and his/her Advance Directive wishes were not followed.Record review revealed Resident ID #1 was readmitted to the facility in October of 2025 with diagnoses including, but not limited to, acute respiratory failure with hypoxia (a condition where the tissues and cells of the body do not receive enough oxygen to function properly), heart failure, and fall. 1. Record review revealed Resident ID #1 had falls on [DATE] and [DATE].Record review of a progress note dated [DATE] at 7:44 PM revealed staff heard the resident yelling out and the resident was found lying in the bathtub with his/her head against the tub.Record review revealed a care plan dated [DATE] revealed the resident was at increased risk for injury related to impaired balance, cognitive impairment, and history of falls with a goal for the resident to remain free from injury.Further review of the care plan failed to reveal evidence that interventions were revised or updated following the resident's fall on [DATE] to address the resident's ongoing and escalating fall risk. 1b. Record review of an undated facility policy titled Resident Falls Documentation Requirements revealed that neurological checks must be initiated following an unwitnessed fall. Record review of a progress note dated [DATE] at 7:20 AM, authored by Licensed Practical Nurse (LPN), Staff D, revealed that the resident experienced an unwitnessed fall and was found on the floor, face down, bleeding from the nose and forehead. Record review failed to reveal evidence that the neuro checks were completed after s/he experienced a fall with a head injury on [DATE], ER facility policy. 2. Record review of a document titled, Advance Directive dated [DATE] revealed instructions for Do Not Resuscitate (DNR). This refers to the withholding of emergency resuscitation in the event of a cardiac arrest.Additional record review revealed the above-mentioned Advance Directive form was signed by the Physician and Resident ID #1 on [DATE].Record review revealed a physician order dated [DATE] confirming a DNR order for the resident.Record revealed the following progress notes: - [DATE] at 1:20 PM: the resident was found without a pulse, respirations, or blood pressure at 1:15 AM. - [DATE] at 2:41 PM authored by LPN, Staff G: 911 was called due to inability to locate the Medical Examiner's contact information in a timely manner. Upon EMS arrival, staff were unable to immediately provide or produce the resident's advance directive documentation, resulting in the initiation of Cardiopulmonary Resuscitation (CPR) by the responders. Record review of an EMS Prehospital Patient Care Report revealed, when first responders arrived at the facility there were no facility staff initially present. EMS documented that the advance directive status could not be verified at the time of care, and CPR was initiated.During a surveyor interview on [DATE] at 8:51 AM with LPN, Staff G, she acknowledged that she was unable to locate the Medical Examiner's telephone number and called 911 for the number. Additionally, she acknowledged she was unable to locate and print the Advance Directive with the DNR status document prior to or upon EMS arrival to the facility and that CPR was initiated by the responders.During a surveyor interview on [DATE] at 1:03 PM, the Director of Nursing Services (DNS) was unable to provide evidence that Resident ID #1's comprehensive care plan was revised to include interventions and approaches for staff to implement following the resident's fall on [DATE]. The DNS acknowledged that the resident sustained a fall with head injury on [DATE] and revealed he would have expected neurological monitoring to have been completed in accordance with the facility policy following the unwitnessed fall with head injury. Additionally, he acknowledged emergency medical (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services (911) were inappropriately summoned to the facility after staff was unable to readily retrieve the Medical Examiner's telephone number. Furthermore, the DNS acknowledged Staff D was unable to produce the resident's Advance Directive for the EMS responder's, resulting in the initiation of CPR despite the resident having a physician order for DNR.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, record review, and staff interview, the facility failed to ensure that a resident receives timely and appropriate pain and symptom management consistent with professional standards of practice, for end-of life-care including the prompt administration of physician-ordered medications for pain and anxiety, for 1 of 2 residents reviewed who were receiving hospice services, Resident ID #1. This failure resulted in the resident experiencing unmanaged pain, terminal agitation, and psychosocial distress during his/her final hours of life.Findings are as follows:According to the American Nurses Association (2018) Position Statement titled, The Ethical Responsibility to Manage Pain and the Suffering It Causes, nurses have an ethical responsibility to relieve pain and suffering through individualized interventions, ongoing assessment, and coordinated approaches to pain management.Record review of a community-reported complaint submitted to the Rhode Island Department of Health on [DATE] alleged Resident ID #1, a hospice resident receiving end-of-life care, experienced terminal agitation and did not receive prescribed comfort medications promptly to provide relief, comfort, and dignity.Record review revealed Resident ID #1 was readmitted to the facility in [DATE] with diagnoses including acute respiratory failure with hypoxia (a condition in which the body does not receive enough oxygen) and heart failure.Review of the resident's care plan dated [DATE] identified a risk for impaired comfort and directed staff to administer pain medication as ordered, monitor the effectiveness of treatment, and observe for non-verbal signs of pain including grimacing and agitation.Review of physician orders revealed the following: - [DATE]: Assess pain every shift - [DATE]: Acetaminophen 975 milligrams every 8 hours for mild painRecord review revealed the resident was admitted to hospice services on [DATE].Review of the hospice admission visit note dated [DATE] at 7:30 PM revealed the resident exhibited signs of respiratory distress, including a respiratory rate of 30 breaths per minute (normal adult range 12-20 breaths per minute), pursed-lip breathing, and pain rated at 6/10. The hospice nurse requested facility staff administer pain medication as needed for symptom management.Record review of the hospice recommendations provided to Licensed Practical Nurse (LPN) Staff A on [DATE] revealed the following medication recommendations: - Morphine concentrate 5 mg every 6 hours - Morphine concentrate 5 mg every 2 hours as needed for pain and shortness of breath - Lorazepam intensol 0.5 mg every 6 hours - Lorazepam intensol 0.5 mg every 2 hours as needed for restlessness and anxietyReview of a nursing progress note dated [DATE] at 7:20 PM authored by Staff A documented the resident was moaning and groaning.Record review failed to reveal evidence the hospice recommendations received on [DATE] were reviewed with the provider. Further review failed to reveal evidence the resident received medication to address the documented pain level of 6/10, moaning, groaning, and respiratory distress.Record review revealed the resident received a follow-up hospice visit on [DATE] at 10:35 AM.Review of the hospice note dated [DATE] revealed the recommendations made on [DATE] had not yet been reviewed, approved, or implemented by the facility.Clinical record review revealed the following provider orders were entered on [DATE]: - Morphine concentrate 5 mg every 6 hours - Morphine concentrate 5 mg every 2 hours as needed for pain and shortness of breath - Lorazepam intensol 0.5 mg every 6 hours - Lorazepam intensol 0.5 mg every 2 hours as needed for restlessness and anxietyReview of the [DATE] Medication Administration Record (MAR) revealed the scheduled Morphine doses due on [DATE] at 5:55 PM and 10:26 PM were marked unavailable.Additional review revealed scheduled lorazepam doses due on [DATE] at 2:04 PM and 10:26 PM were also marked unavailable.Record review failed to reveal evidence the provider was notified the resident missed scheduled doses of Morphine and lorazepam.Record review revealed the pharmacy delivered Morphine to the facility on [DATE] at 11:03 PM.During surveyor observation on [DATE] at approximately 2:30 PM, Morphine 20 mg/ml was observed available in the facility's Pyxis MedStation, an automated medication dispensing system.During interview on [DATE] at approximately 2:35 PM, LPN Staff B (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	acknowledged Morphine was available in the Pyxis system and stated staff could access the medication using a pharmacy-issued code.During interview on [DATE] at 3:10 PM, Staff A stated the hospice nurse reviewed the medication recommendations with her on [DATE]. Staff A further acknowledged she did not notify the Nurse Practitioner the resident had been seen by hospice and failed to communicate the hospice medication recommendations.During interview on [DATE] at 12:14 PM, Registered Nurse (RN) Staff C stated she did not have access to the Pyxis system because she was an agency nurse. Staff C further acknowledged she did not seek assistance from another staff member to obtain the medication for the resident.Further record review failed to reveal evidence that any effective pain relief interventions were offered, refused, or implemented from [DATE] at 7:20 PM until [DATE] at 12:00 AM, when the resident received the first documented dose of Morphine.Review of a nursing progress note dated [DATE] at 7:20 PM revealed the resident experienced an unwitnessed fall and was found face down on the floor bleeding from the nose and forehead. Hospice was notified.Review of a hospice note dated [DATE] at 7:45 PM revealed the resident sustained a forehead laceration and hematoma and was observed restless, moaning, and calling out.Further hospice documentation revealed the resident had an elevated heart rate of 128 beats per minute (normal adult range 60-100), rapid breathing, shallow and labored respirations, pursed-lip breathing, and visible respiratory distress. The hospice nurse documented the previously administered Morphine and lorazepam had poor effect and requested additional as-needed doses during the visit, which also had little or no effect.The hospice nurse further recommended immediate escalation of comfort measures including: - Discontinue previous Morphine orders - STAT (immediately and without delay) dose of Morphine 10 mg - STAT dose of lorazepam 1 mg - Morphine 10 mg every 4 hours scheduled - Morphine 10 mg every 1 hour as needed for pain and shortness of breathReview of the [DATE] MAR revealed the resident received Morphine 5 mg at 8:43 PM from the previous as-needed order approximately one hour after the hospice nurse recommended immediate STAT dosing, despite continued signs of distress including moaning and restlessness.Record review failed to reveal evidence that staff performed a follow-up assessment to determine whether the medication relieved the resident's symptoms.Review of a progress note dated [DATE] at 9:47 PM revealed the provider approved the hospice recommendations.Further clinical record review failed to reveal evidence the STAT Morphine and lorazepam doses were administered as recommended following provider approval.Record review revealed the resident expired on [DATE] at 1:15 AM.During interview on [DATE] at 1:03 PM, the Director of Nursing Services was unable to provide evidence hospice recommendations for pain and symptom management were reviewed and implemented timely. He further acknowledged facility staff failed to utilize Morphine available in the Pyxis MedStation system.During interview on [DATE] at 2:24 PM, the resident's physician stated it would be expected that hospice recommendations be implemented as soon as possible in end-of-life situations, as the goal of care is relief of pain and suffering.Due to the facility's failure to timely review and implement hospice recommendations and administer available comfort medications, the facility failed to provide appropriate end-of-life care and symptom management for Resident ID #1. As a result, the resident experienced unnecessary and avoidable pain, unmanaged terminal agitation, respiratory distress, and psychosocial suffering during the final hours of life.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on clinical record review and staff interview, it has been determined that the facility failed to ensure that hospice services meet professional standards of principles that apply to individuals providing services in the facility for 1 of 2 residents reviewed who are receiving hospice services, Resident ID #1.Findings are as follows:Record review of a community-reported complaint submitted to the Rhode Island Department of Health on 5/5/2026 alleged that Resident ID #1 was admitted to hospice services on 5/1/2026. Additionally, the complaint alleged s/he was experiencing terminal agitation and the facility failed to timely implement hospice recommendations promptly to provide comfort, relief, and dignity at the end of his/her life. Record review revealed that Resident ID #1 was readmitted to the facility in October of 2025 with diagnoses including, but not limited to, acute respiratory failure with hypoxia (a condition where the tissues and cells of the body do not receive enough oxygen to function properly) and heart failure.Record review revealed that the resident was admitted to hospice services in May of 2026.Review of the resident's electronic and paper medical record failed to reveal evidence that the required hospice documentation was maintained and readily accessible including the following: - The most recent hospice plan of care- Hospice election form- Physician certification and recertification of the terminal illness- Names and contact information for hospice personnel involved in hospice care- Instructions on how to access the hospice's 24-hour on-call system- Hospice medication information- Hospice physician and attending physician ordersAdditional record review failed to reveal evidence of Hospice Recommendation forms for all hospice nursing visits. These forms are utilized by hospice to communicate resident assessments, clinical updates, and recommendations to facility staff to support continuity of care. During a surveyor interview on 5/8/2026 at 1:03 PM, with the Director of Nursing Services (DNS), he revealed that the facility does not have individual hospice binders for each resident receiving hospice services and indicated that all hospice documents should be scanned into the electronic medical record. The DNS was unable to provide evidence that the above-mentioned hospice documents including all hospice recommendation forms were present in the resident's medical record.