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	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holiday Operator, LLC Dba Holiday Rehabilitation A	30 Sayles Hill Road Manville, RI 02838

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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 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 #2.Findings are as follows:Review of a community reported complaint submitted to the Rhode Island Department of Health on 5/29/2026 alleged that Resident ID #2 was identified with new significant bruising. The resident's spouse had visited the resident the night prior and there was no bruising. The report further alleged that when the complainant asked about the incident s/he was told two Nursing Assistants (NA) used the wrong equipment to transfer the resident.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 Resident ID #2 was originally admitted to the facility in February of 2026 with diagnoses including, but not limited to, dementia with behavioral disturbance, muscle weakness and falls.Record review of the progress notes revealed the following:-5/13/2026 at 8:09 AM, a deep purple discoloration/bruise was identified on the resident's left upper arm.-5/14/2026 at 11:47 AM authored by the Assistant Director of Nursing (ADON) revealed that after talking with staff, the bruise appears to be due to improper positioning of the resident's arm during transfers. Further, review revealed the progress note was documented as a late entry on 5/19/2026 at 11:49 AM, six days after the bruising was identified.During a surveyor interview on 6/8/2026 at 12:09 PM, with the resident's spouse s/he indicated that s/he received a call from facility staff on 5/13/2026 to inform him/her of new bruising to his/her spouse's left arm. Additionally, s/he indicated when s/he visited the night before there was no bruising present. Further, s/he revealed that the facility staff indicated there would be an investigation into the cause of the bruising but as of 6/8/2026 s/he had not heard back.Record review of the facility nursing schedule revealed Staff D and G were assigned to care for the resident on 5/12/2026 during the 11:00 AM to 7:00 AM shift.Further record review failed to reveal evidence that staff witness statements were collected from Staff D and G relative to the injury of unknown origin per the facility policy.During surveyor interviews on 6/9/2026 at 12:55 PM and 1:28 PM with the Assistant Director of Nursing Services, she revealed that the bruising was not present on 5/12/2026 when the resident's spouse visited and believes an inappropriate transfer occurred by pulling on the resident's arm between 5/12/2026 and when the bruising was identified through 5/13/2026 at approximately 8:00 AM. Further record review failed to reveal evidence that a thorough investigation had been conducted to determine the origin of the bruising.Cross reference F689.

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, and staff and resident interview, the facility failed ensure that Resident ID #2's environment remained free of accident hazards, as possible, relative to the resident's assessed transfer needs and facility policy. Specifically, the facility failed to implement the Physical Therapist's recommendation for the use of a mechanical lift following the resident's identified decline in strength and mobility on 5/11/2026 and failed to ensure staff utilized a gait belt during manual transfers. As a result, Resident ID #2 was subjected to unsafe transfer practices including, being lifted under the arm and elbow area, which resulted in swelling, extensive bruising, and increased pain to the resident's left upper extremity. Requiring medical evaluation, diagnostic testing, pain medication, and ongoing monitoring. These failures resulted in actual harm for 1 of 1 resident reviewed with an injury of unknown origin, Resident ID #2.Based on clinical record review and staff and resident interviews, the facility failed to ensure that Resident ID #2's environment remained free of accident hazards, as possible, relative to the resident's assessed transfer needs and facility policy. The failure of the facility to implement a recommendation of a mechanical lift on 5/11/2026, resulted in actual harm including swelling, extensive bruising, and increased pain to the resident's left upper extremity for Resident ID #2.Findings are as follows:Review of a community reported complaint submitted to the Rhode Island Department of Health on 5/29/2026 alleged that Resident ID #2 was discovered with significant bruising. The resident's spouse had visited the resident the night prior and there was no bruising. The report further alleged that when the complainant asked about the incident s/he was told two Nursing Assistants (NA) used the wrong equipment to transfer the resident.Review of a facility policy titled, SAFE PATIENT HANDLING AND MOVEMENT POLICY states in part, .to ensure that its .residents are cared for safely.direct care staff on high/risk .resident care areas should assess high risk patient handling tasks in advance to determine the safest way to accomplish them.mechanical lifting equipment.should be used to prevent lifting and handling of patients/residents when absolutely necessary.it is the duty of employees to take reasonable care of their health and safety.and their patients.by following this policy. Non-compliance will indicate the need for retraining.All patients are assessed by a nurse on admission, and with any changes, for the safest and most appropriate method of transfer. This is documented on the Smooth Moves Resident Handling Assessment .Patient handling and movement requirements.use of mechanical lifting devices and other approved patient handling aids (devices designed to help nursing staff and other direct care workers safely lift, move, and reposition residents without overexertion, i.e. Gait Belts, a safety device worn around the resident's waist over the clothes to aid caregivers in safely supporting and transferring individuals with mobility challenges).training: Staff to complete and document training as required to correct improper use/understanding of safe patient handling and movement.Record review revealed Resident ID #2 was originally admitted to the facility in February of 2026 with diagnoses including, but not limited to, dementia with behavioral disturbance, muscle weakness, and falls.Record review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status Score of 4 out of 10, indicating the resident has severe cognitive impairment. Additional review revealed the resident is totally dependent (The helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) with dressing, toileting, and transfers.Record review of the resident's Kardex (NA Care plan-a documentation system that enables nurses to write, organize, and easily reference key resident information that shapes a nursing care plan) revealed the resident requires substantial/maximum assistance, or is totally dependent of the staff to safely transfer from a sitting to standing position.1a. Record review of a Physical Therapy (PT) Evaluation dated 5/11/2026 revealed the resident experienced a new onset of muscle weakness and difficulty walking.Record review of a PT (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Encounter Note dated 5/11/2026 revealed the Physical Therapist, Staff A, discussed with nursing that the resident requires a mechanical lift (a device designed to safety transfer individuals with limited mobility that cannot safely move from one surface to another) for transfers until the resident is consistent with transfers for everyone's safety. Additional review revealed the resident's Kardex was updated to reflect the need for a mechanical lift transfer.Record review failed to reveal evidence that a new Smooth Moves assessment was completed for the resident after his/her change in transfer status was identified on 5/11/2026, per facility policy.Review of the Kardex revealed Resident ID #2 required a mechanical lift for transfers with the assist of two staff members.Record review revealed the following progress notes:-5/13/2026 at 5:19 AM, the resident was seen by the Nurse Practitioner (NP) swelling and bruising to the left arm. Additionally, new orders were given to elevate the left arm, obtain a PT/INR (a blood test that checks how quickly the blood clots) and a STAT (immediate) ultrasound of the left arm.-5/13/2026 at 8:09 AM, a deep purple discoloration/bruise was identified on the resident's left upper arm.-5/13/2026 at 9:48 PM the resident continues with swelling to the left hand and bruising to the left arm.-5/14/2026 at 12:00 AM authored by the NP revealed the PT/INR results were within normal limits indicating the resident's blood was clotting normally.Additional review of the progress note revealed the following new orders were given:-Hold the resident's Eliquis (a medication prescribed to thin the blood) for two days-Obtain an x-ray of the resident's left arm ordered to evaluate a contusion, redness and swelling of the left upper arm. -Tramadol (a medication prescribed to treat moderate to severe pain) 25 milligrams (MG) twice daily for pain.-5/14/2026 at 6:47 AM the resident woke up around 1:00 AM complaining of knee and left arm pain.Record review of a progress note dated 5/14/2026 at 11:47 AM authored by the Assistant Director of Nursing (ADON) revealed that after talking with staff, the bruise appears to be due to improper positioning of the resident's arm during transfers. Further, review revealed the progress note was documented as a late entry on 5/19/2026 at 11:49 AM, six days after the bruising was identified.During a surveyor interview on 6/8/2026 at 12:09 PM, with the resident's spouse, s/he indicated that s/he received a call from facility staff on 5/13/2026 to inform him/her of new bruising to his/her spouse's left arm. Additionally, s/he indicated when s/he visited the night before there was no bruising present. Further, s/he revealed that the facility staff indicated there would be an investigation into the cause of the bruising but as of 6/8/2026 the spouse had not heard back.During a surveyor interview on 6/9/2026 at approximately 8:15 AM, with Registered Nurse (RN), Staff B, she indicated that she was not aware that the resident had been evaluated by PT on 5/11/2026 with the recommendation to utilize a mechanical lift for transfers for safety. Additionally, she indicated that she spoke with the NA, Staff C, working on the unit and she indicated that the resident transfers with the assistance of two staff members without a mechanical lift. Further she indicated that when she spoke with NA, Staff C, she reported that the resident was experiencing weakness and difficulty with his/her manual transfers. The RN, Staff B, changed his/her transfer status to utilize a mechanical lift on 5/13/2026 for safety, although staff B was not aware that the resident had been evaluated by PT on 5/11/2026 and his/her transfer status was changed to a mechanical lift.During a surveyor interview with NA, Staff C, on 6/9/2026 at 8:57 AM she acknowledged that she was assigned to care for the resident on 5/12/2026 during the 3:00 PM to 11:00 PM shift. She revealed that she was not aware of the PT recommendation for a mechanical lift transfer and acknowledged that she transferred the resident manually with another staff member. Further, she indicated that at times the resident is dead weight and is difficult to lift manually.During a surveyor interview with NA, Staff E, she revealed that she worked the evening of 5/11/2026 during the 3:00 PM to 11:00 PM shift and transferred the resident manually with another staff member. Additionally, she indicated that she was not made aware of the PT recommendation for a mechanical lift for transfer given on 5/11/2026. During a surveyor interview on 6/9/2026 at 9:46 AM with Licensed Practical Nurse, Staff F, she revealed that she was the nurse assigned to the resident on 11:00 PM to 7:00 AM shifts on 5/11/2026, 5/12/2026, and 5/13/2026. Additionally, she indicated she was not aware of the recommendation from PT made (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	on 5/11/2026 for the use of a mechanical lift for transfers. Further, she indicated that on the above-mentioned shifts staff were transferring the resident manually with two staff members. During a surveyor interview on 6/9/2026 at 11:39 AM with NA, Staff G, she acknowledged that she was assigned to care for the resident on 5/12/2026 during the 11:00 PM to 7:00 AM shift along with NA, Staff D. She revealed that she was not given a report from the nurse that the resident required a mechanical lift for transfers. Additionally, she acknowledged that she assisted Staff D, in transferring the resident from the wheelchair into the recliner manually by lifting the resident under his/her arm/elbow area. During a surveyor interview on 6/9/2026 at 12:40 PM with the Director of Nursing Services, he indicated it would be his expectation for staff to utilize a mechanical lift to transfer the resident after the recommendation was made by PT on 5/11/2026.1b. Review of a facility policy titled [Facility] Gait Belt Policy and Procedure states in part, it is the policy of [Facility] to use a gait belt for all resident transfers and ambulation.During a surveyor interview on 6/9/2026 at 8:39 AM with NA, Staff D, she acknowledged she worked the 11:00 PM to 7:00 AM shift on 5/12/2026 and provided care for the Resident ID #2. Additionally, she revealed she attempted to transfer the resident to the toilet by grabbing his/her pants and lifting him/her under the arm without using a gait belt. Further, Staff D stated that the resident required two staff members utilizing a manual transfer method.During a surveyor interview on 6/9/2026 at 11:39 AM with NA, Staff G, she acknowledged that she was assigned to care for the resident on 5/12/2026 during the 11:00 PM to 7:00 AM shift along with Staff D. Staff G, acknowledged that she did not utilize a gait belt to transfer the resident.During surveyor interviews on 6/8/2026 at 12:54 PM, 6/9/2026 at 12:55 PM, and 1:28 PM with the Assistant Director of Nursing Services, she indicated that it would be her expectation for staff to utilize a gait belt during manual transfers. Additionally, she revealed that the bruising was not present on 5/12/2026 when the resident's spouse visited and believes an inappropriate transfer occurred by pulling on the resident's arm between 5/12/2026 and when the bruising was identified on 5/13/2026 at approximately 8:00 AM. During a surveyor interview on 6/10/2026 at 1:48 PM with the Medical Director he revealed it would be his expectation that staff would have implemented the recommendation made by PT on 5/11/2026, prior to the next time they transferred the resident. The facility's failure to timely implement the Physical Therapist's recommendation for a mechanical lift, communicate the resident's change in transfer status to direct care staff, complete a revised transfer assessment, and ensure staff utilized a gait belt during resident transfers resulted in Resident ID #2 being transferred utilizing unsafe transfer techniques. Consequently, the resident sustained swelling, significant bruising, and pain to the left upper extremity, requiring physician assessment, diagnostic testing, medication changes, pain management interventions, and continued clinical monitoring. The deficient practice resulted in actual harm to the resident. Cross Reference F610.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and resident and staff interviews, the facility failed to provide dental services for 1 of 2 residents reviewed with dentures, Resident ID #1. Additionally, the facility failed to have a policy that addressed instances when a resident's dentures are lost or damaged.Findings are as follows:Record review of a community reported complaint submitted to Rhode Island Department of Health on 5/29/2026, alleged the resident's family has been required to purchase several sets of dentures lost by the facility.Record review revealed the resident was originally admitted to the facility in September of 2022 with diagnoses including, but not limited to, stroke and dysphagia (difficulty swallowing).Record review of a Significant Change Minimum Data Set assessment dated [DATE] revealed, the resident is edentulous (having no natural teeth).Record review revealed a Brief Interview for Mental Status dated 6/4/2026 with a score of 12 out of 15, indicating moderately impaired cognition.Record review failed to reveal evidence identifying when the resident's bottom denture was misplaced.During a surveyor interview on 6/7/2026 at approximately 12:00 PM, with the Medical Director, he revealed it would be his expectation for the facility to have coordinated a follow-up appointment up to address the loss of the bottom denture.1a. During a surveyor interview on 6/9/2026 at approximately 1:30 PM, with the resident, s/he indicated that his/her bottom denture has been missing and s/he has lost his/her appetite due to the lack of dentures.Record review of a care plan dated 2/12/2026 revealed, the resident is edentulous with interventions, including but not limited to, ensure the dentures are provided to the resident and assist the resident with placement.During a surveyor interview on 6/8/2026 at 12:54 PM, and email correspondence on 6/10/2026 at 10:21 AM, with the Assistant Director of Nursing Services (ADNS), she acknowledged that the residents' lower denture is missing and indicated the loss occurred sometime after 5/18/2026. Additionally, she was unable to provide evidence that a follow up appointment had been made for the resident. 1b. Record review failed to reveal evidence of a facility policy that addresses instances when a resident's dentures are lost or damaged. During a surveyor interview via email correspondence on 6/10/2026 at 10:21 AM with the ADNS, she acknowledged that the facility failed to have a policy that to include language for circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures, as required.