

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415079	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Cedar Haven Operations Holding LLC Valley View Hea		STREET ADDRESS, CITY, STATE, ZIP CODE 4 St Joseph Street Woonsocket, RI 02895	
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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observations, clinical record review, and resident and staff interviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public, for 3 of 4 units observed. Findings are as follows: Review of an undated facility policy titled Housekeeping and Maintenance Services states in part, Objective. To provide a safe, sanitary and clean environment for the residence in the facility .1. Review of a community report complaint submitted to the Rhode Island Department of Health on 6/15/2026, revealed Resident ID #39's family member saw a rat in the resident's room on 6/12/2026. Further review revealed staff were made aware of the sighting and stated that the facility is aware of the problem. Additionally, the complaint revealed that the resident is immobile and wouldn't be able to get away from the rodent if it crawled into the bed. Record review revealed Resident ID #39 was admitted to the facility in May of 2026 with diagnoses including, but not limited to, metabolic encephalopathy (a brain dysfunction) and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed a BIMS score of 6 out of 15, indicating severely impaired cognition. Further review revealed the resident is dependent on staff for activities of daily living and transfers. During a surveyor interview on 6/16/2026, at approximately 2:10 PM with Resident ID #39, s/he revealed that his/her family saw a mouse in his/her room recently and that mice were found in his/her roommate's bed. A surveyor observation on 6/8/2026 at 10:20 AM of the 3rd floor unit revealed a rodent walking under the baseboard heater of Resident ID #121's room. Review of the facility's service agreement with Allstate Pest Control signed on 3/4/2026, revealed the contracted service was for Bi-Weekly Rodent (Mice) Control. Review of the Rodent Monitoring Service Reports revealed that the pest control company set traps in the facility on 4/1/2026, 4/28/2026, and 5/15/2026. Further review failed to reveal evidence of bi-weekly rodent control, per the service agreement. During a surveyor interview on 6/15/2026 at 2:43 PM with the Administrator, she revealed that mice in the building was a concern recently discussed in the resident council meeting. She further revealed that bi-weekly rodent control was completed when the service agreement was originally signed, however, they decreased the visits to approximately every three weeks as they thought the rodent issue was improving. 2. Surveyors' observations on all days of the survey, 3 of 4 units were observed with strong foul odors. These odors could be smelled from the hallways, inside resident rooms, and the bathrooms. Although all 7 surveyors observed foul odors throughout each day of the survey, facility staff members were willing to acknowledge their presence. 3. Record review revealed Resident ID #152 was admitted to the facility in November of 2024 with a diagnosis including, but not limited to, heart failure (when the heart muscle is too weak or stiff to pump enough oxygen-rich blood to meet the body's needs). Review of an MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11 (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 415079	Facility ID: 415079
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	out of 15, indicating moderate cognitive impairment. During a surveyor interview on 6/8/2026 at 9:50 AM with the resident, s/he stated that his/her bed has not been made by the staff in three to four days and the staff does not wash the floor in his/her room. Additionally, the resident stated that his/her bedside table has been broken for months and has exposed sharp edges on the right corner of the table. Surveyor observation immediately following the above-mentioned interview revealed the bedside table was broken with exposed sharp edges. Additionally, the floor in the resident's room was sticky with noticeable discolored footprints. An additional surveyor observation on 6/9/2026 at 8:25 AM, of the resident's room, revealed the floor was still sticky, and the bedside table was in the same condition as observed on the previous day. During a simultaneous surveyor observation and interview of the above-mentioned resident's room on 6/10/2026 at 9:11 AM, in the presence of Nursing Assistant (NA), Staff A, she acknowledged the floor was sticky and the bedside table was broken. During a surveyor interview on 6/10/2026 at 9:17 AM with Licensed Practical Nurse, Staff B, she stated that she was not aware the bedside table was broken. She stated that any broken furniture in the residents' rooms should be put in the maintenance log to be repaired. Additionally, Staff B stated, the toilet in the resident's room frequently requires plunging and has flooded onto the floor. Record review of a maintenance log, that is kept at the nurse's station, dated 6/2/2026 through 6/9/2026, failed to reveal evidence that the resident's broken bedside table was in documented in the maintenance log. During a surveyor interview on 6/11/2026 at 11:27 AM with a [NAME] (janitor), Staff C, he stated that he is responsible for cleaning the hallways, nurses' stations and the day room (general sitting area on the unit). Additionally, Staff C indicated that they do not clean residents' rooms, they are cleaned by the housekeeping staff. During a surveyor interview on 6/11/2026 at 11:44 AM with a housekeeper, Staff D, she stated that the housekeeping role includes cleaning the residents' rooms, bathrooms including the toilets, sweeping, and mopping the floors. Staff D further stated that the residents' rooms and bathrooms are cleaned daily and if there are spills or areas that are expected to be clean after the housekeeping staff have completed their task, the NAs are expected to clean up those areas. During a surveyor interview on 6/11/2026 at 11:57 AM, with the Maintenance Director, he was unable to provide evidence that Resident ID #152's bedside table had been repaired or that his/her floor had been cleaned, prior to it being brought to the facility's attention by the surveyor. 4. Record review revealed Resident ID #75 was admitted to the facility in April of 2024 with a diagnosis including, but not limited to, paranoid schizophrenia. During a surveyor interview on 6/8/2026 at 1:19 PM, with Resident ID #75, s/he revealed that the staff does not regularly wash his/her room floor. During a surveyor observation immediately following the above-mentioned interview, cereal was observed on the floor in the resident's room and the floor was sticky. 5. Record review revealed Resident ID #106 was admitted to the facility in November of 2025 with a diagnosis including, but not limited to, paranoid schizophrenia. During surveyor observations on 6/8/2026 at 1:39 PM and on 6/9/2026 at 8:27 AM, of Resident ID #106's room, revealed dark red and brown smears on the floor measuring approximately 1 foot (ft.) by 1ft. in length and two smaller smears were observed towards the bathroom. During a surveyor interview on 6/11/2026 at 12:06 PM with the Director of Nursing Services, she was unable to provide evidence that the facility provided a safe, functional, sanitary, and comfortable environment for the residents, as required.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observations, clinical record reviews, and staff interviews, the facility failed to ensure that services were provided in accordance with professional standards of quality relative to not following physician orders, for 3 of 3 residents. This included failing to change a wound dressing daily, as ordered, for Resident #10, failing to implement interventions related to weight loss, for Resident #11, and failing to provide seizure pads while in bed, as ordered, for Resident #157. Findings are as follows: 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. 1. Record review revealed Resident ID #10 was admitted to the facility in October of 2025 with a diagnosis including, but not limited to, spinal stenosis (the narrowing of the spaces within the spine, which places pressure on your spinal cord and the nerves that branch out to the body). Record review of a physician's order dated 4/15/2026, revealed to cleanse the third and fourth toes on the left foot with a wound cleanser, apply wound gel, and cover with an island border gauze (wound dressing) every evening. Record review of the June 2026 Treatment Administration Record (TAR) revealed the order was signed off as being completed on 6/10/2026. During a surveyor observation on 6/11/2026 at 9:35 AM, the resident was observed in bed with a dressing to his/her left foot that was dated 6/9/2026, with staff initials indicating PT. During a surveyor observation on 6/11/2026 at 9:47 AM, in the presence of the third-floor unit manager, Staff E, she acknowledged the dressing on the resident's left foot was dated 6/9/2026. During a surveyor interview immediately following the above-mentioned observation, Staff E indicated that she would expect the dressing to be changed daily, as ordered, and initiated by the nurse who completed the treatment. During a surveyor interview on 6/11/2026 at 11:16 AM with Licensed Practical Nurse, Staff F, she acknowledged that she did not change the resident's dressing on 6/10/2026, as ordered. Additionally, Staff F acknowledged that she had inaccurately signed off the order as being completed on 6/10/2026, even though she did not complete the dressing change. During a surveyor interview on 6/11/2026 at 11:35 AM with the Director of Nursing Services (DNS), she stated that she would expect the resident's dressing to be changed daily, as ordered. 2. Record review revealed Resident ID #11 was admitted to the facility in October of 2025 with diagnoses including, but not limited to, major depressive disorder and hereditary spastic paraplegia (progressive genetic disorders characterized by chronic weakness, stiffness, and cramping in the leg muscles). Record review of a quarterly Minimum Data Set assessment dated [DATE], revealed that the resident is dependent on staff for eating and s/he weighs 97 pounds (lbs.). Record review revealed the following weights were obtained: - 6/2/2026 and 6/3/2026: 84.2 lbs. - 5/4/2026: 97.2 lbs. Record review of a physician's progress note dated 6/5/2026, revealed a visit was completed for a significant unintentional weight loss, and the resident was found to be cachectic (a state of physical wasting, severe weight loss, and extreme muscle weakness caused by a serious underlying illness) in appearance. Additionally, the progress note revealed that a recent medication change was completed which included an order for Remeron (a medication prescribed to treat depression and frequently used to stimulate appetite). Record review of a nursing progress note authored by the Unit manager (UM), Staff E dated 6/5/2026, revealed the resident had a 13 lb. weight loss since the last monthly weight and there is a new order for Remeron 7.5 milligram (mg), daily at bedtime for appetite stimulation. Record review of a nutrition/dietary progress note dated 6/7/2026, revealed the nursing staff reported that on 6/2/2026 the resident weighed 84.2 lbs. which is 13.3% weight loss over a (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	month. Additionally, the note revealed that the resident was started on Remeron. During a surveyor interview on 6/9/2026 at approximately 12:20 PM, with Licensed Practical Nurse, Staff G, she revealed that the resident has been losing weight and that s/he is receiving Remeron to improve his/her appetite. Record review failed to reveal evidence that the Remeron order was initiated, or the resident's responsible party had been notified to approve the Remeron order from 6/5/2026, until it was brought to the facility's attention by the surveyor on 6/9/2026. During a surveyor interview on 6/10/2026 at 11:42 AM, with UM, Staff E, she was unable to provide evidence the order for Remeron had been implemented since 6/5/2026, as she had indicated in her progress note on 6/5/2026. During a surveyor interview on 6/11/2026 at 11:43 AM, with the DNS, she revealed that she would expect the staff to have notified the resident's responsible party for approval of the new order for Remeron when the order was given by the provider on 6/5/2026. Additionally, the DNS stated that the staff is expected to notify the responsible party on the same day or the following day. 3. Record review revealed Resident ID #157 was admitted to the facility in September of 2024 with diagnoses including, but is not limited to, fracture skull and cerebral edema (swelling of the brain). Review of a care plan dated 2/25/2025, revealed the resident is at risk for skin impairment related to fragile skin. Staff intervention includes, but not limited to, applying seizure pads to bed rails for safety. Record review revealed a physician order dated 9/13/2024 for bilateral seizure pads on upper side rails while in bed related to tremors for safety and injury prevention. Surveyor observations on the following dates and times the resident was observed in bed without the bilateral seizure pads on the bed rails, as ordered:- 6/8/2026 at 1:34 PM- 6/9/2026 at 8:41 AM, 8:57 AM, 11:12 AM, and at 1:09 PM. During a surveyor observation and interview on 6/09/2026 at approximately 1:46 PM, in the presence of Registered Nurse, Staff H, she acknowledged that the resident was in bed and the seizure pads were not on the bed rails, as ordered. Additionally, she acknowledged that she had signed off the TAR on 6/9/2026 indicating that the resident's seizure pads were on the bed rails when they were not. During a surveyor interview on 6/10/2026 at 1:07 PM, with the DNS, in the presence of the Administrator, she was unable to provide evidence that the resident's seizure pads were on his/her bed rails, as ordered. Additionally, the Administrator stated that she would expect the nurse to verify that the seizure pads were on the bed rails before signing off the order on the TAR.		

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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, surveyor observation, and staff interview, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice relative to 1 of 1 resident reviewed who complained of chest pain and requested a hospital transfer, Resident ID #104. Findings are as follows: Review of a community report complaint submitted to the Rhode Island Department of Health on 6/15/2026 alleged Resident ID #104 was hospitalized after s/he had walked from the facility to a nearby building to have someone call 911. Further review of the complaint alleged the facility staff would not call an ambulance for the resident who thought s/he was having another stroke as s/he was feeling unwell with shortness of breath and pain. Additional review alleged that the resident reported that s/he refused to allow the nursing staff at the facility to take his/her vital signs because s/he felt unsafe, however s/he felt unwell and needed to go to the hospital. Record review revealed Resident ID #104 was admitted to the facility in March of 2026 with diagnoses including, but not limited to, hypertension (high blood pressure) and a history of a Transient Cerebral Ischemic Attack (TIA- a temporary blockage of blood flow to the brain, often referred to as a mini-stroke, and serves as a critical warning sign for potential future strokes). Review of a Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 13 out of 15, indicating intact cognition. Record review of the Medical Orders about Life-Sustaining Treatment (MOLST), signed by the resident on 3/29/2026, revealed that in the event of cardiac or respiratory arrest, do not resuscitate. Further review revealed the resident wished to be transferred to the hospital when necessary. Review of a progress note dated 6/12/2026 at 6:43 AM, authored by Registered Nurse (RN), Staff T, revealed the resident went to the nurse's station around 2:00 AM complaining about his/her roommate then spent the rest of the night sitting in a chair dozing on and off. Further review revealed a few hours later the resident approached the nurse stating that s/he was experiencing chest pain and the nurse wanted to obtain vital signs, however the resident became angry and walked away. Additional review revealed about 10 minutes later the resident was seen in the reception area and moments later staff stopped him/her as s/he was going into the street, the rescue was called and the resident was sent to the hospital. During a surveyor interview on 6/16/2026 at 10:13 AM with RN, Staff T, she revealed that on 6/12/2026 around 4:00 AM, Resident ID #104 complained of chest pain and requested to go to the hospital. She revealed that she told the resident that she needed to obtain vital signs and call the doctor and the resident said whatever and walked away. She further revealed that approximately an hour later she observed the resident walking around the facility's reception area and that the resident usually wasn't up at that time. Staff T revealed that she received a call from the Administrator at approximately 6:00 AM, informing her that the resident had left the building and another nurse was going down the street after him/her. Furthermore, she revealed that she failed to contact a provider or send the resident to the hospital after the resident had complained of chest pain at approximately 4:00 AM. During a surveyor interview on 6/16/2026 at 10:31 AM, with Licensed Practical Nurse (LPN), Staff U, she revealed that she was working on the ground floor on the morning of 6/12/2026 when the cook alerted her that a resident was seen walking down the steep street away from the facility at approximately 6:00 AM. She further revealed that when she exited the facility initially, she couldn't see the resident and another staff member pointed to indicate that the resident had turned onto a nearby street. Staff U revealed that she caught up with the resident on the street with another staff member following in a car and attempted to talk to the resident, however s/he was angry and said that s/he was going to the hospital. She revealed that the resident was (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sweating and continued to walk at a fast pace until s/he arrived at an apartment complex, approximately a half mile from the facility. Furthermore, she revealed that the physical therapy staff called 911 at that time, emergency medical staff and the police arrived at the apartment complex, and the resident was transported to the hospital. During a surveyor interview on 6/16/2026 at approximately 11:40 AM, with Physical Therapy Assistant, Staff V, she revealed that shortly after 6:00 AM on 6/12/2026 she was notified that a resident was walking down the street away from the facility so she drove down the street with another staff member until she found the resident, at which time she exited the vehicle and started walking with the resident. She further revealed that once they arrived at the apartment complex the resident was asking people there to call 911 so at that time, she herself contacted 911 for the resident. During a surveyor interview on 6/16/2026 at 11:50 AM with the Cook, Staff W, he revealed that around 6:00 AM on 6/12/2026 a Dietary Aide, Staff X, entered the building and indicated that he observed a resident walking down the street away from the facility. He further revealed that he exited the building and observed the resident walking down the street. He then went inside to alert a nurse as the dietary aide went down the street after the resident. Review of the EMS (Emergency Medical Service) Patient Care Report dated 6/12/2026, revealed EMS was dispatched at 6:19 AM and responded to an apartment building where the resident was sitting on a bench experiencing chest pain. Further review revealed the resident stated his/her chest pain level was five out of ten that began approximately 6 hours prior. Additional review revealed an intravenous (IV) catheter was established, aspirin was administered by mouth, and nitroglycerin spray (a medication prescribed to treat chest pain by relaxing the blood vessels) was administered sublingually (under the tongue) enroute to the hospital, where the resident was transferred to the emergency department. Review of the hospital documentation with a discharge date of 6/15/2026, revealed the resident presented to the emergency department on 6/12/2026 with chest pain and was noted to have worsening dysarthria (slow or slurred speech) and subtle right sided facial weakness at 7:15 AM. Further review revealed a CT (computed tomography) scan was performed with results indicating a stable thrombosed left internal mammary artery aneurysm (a potentially life threatening vascular lesion of the artery that supplies the chest wall and heart often associated with underlying vascular disease) and no large vessel occlusion. The resident was admitted to the hospital on [DATE] to rule out a TIA (Transient Ischemic Attack, a temporary blockage of blood flow to the brain, often referred to as a mini-stroke) or acute ischemic stroke. Additionally, the resident was discharged on 6/15/2026 to a different skilled nursing facility per the resident's request with the diagnosis of a suspected acute subcortical stroke (a stroke that occurs in the deep regions of the brain). Furthermore, the resident was discharged with a new order for aspirin daily (a medication prescribed to assist in preventing a heart attack or stroke). During a surveyor interview on 6/16/2026 at 12:44 PM, with the Medical Director, he stated that he was made aware that the resident went AWOL (Absent Without Official Leave) and then sent to the hospital via 911 on 6/12/2026 when he entered the facility later that day. He further stated that he did not think another provider was contacted prior to him entering the building on 6/12/2026. Additionally, he stated that he would expect the nurse to contact the on-call provider if a resident complains of chest pain and that it is the standard of practice to notify a resident's power of attorney (POA) when they are sent to the hospital. During a surveyor interview on 6/16/2026 at approximately 12:20 PM and at 2:43 PM with the Administrator, in the presence of the Director of Nursing Services, she revealed the resident left the facility on the morning of 6/12/2026 because s/he wanted to go to the hospital. She further acknowledged that the nurse did not call 911 or notify the provider following the resident's complaints of chest pain on 6/12/2026. Additionally, she could not provide evidence that the resident's POA was notified when the resident unexpectedly left the facility and was admitted to the hospital.		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, and staff and resident interviews, the facility failed to provide treatment and care to maintain good foot health for 1 of 1 resident reviewed who complained of foot pain who is a type II diabetic and has a history of diabetic foot ulcers, Resident ID #40. Findings are as follows: Record review revealed the resident was admitted to the facility in December of 2021. Review of a Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status score of 9 out of 15, indicating moderately impaired cognition. Further review revealed the resident is dependent on staff for activities of daily living including bathing, and applying and removing footwear. Review of the care plan revealed the resident has a potential for skin impairment related to fragile skin. Review of a weekly body check dated 6/3/2026 failed to reveal evidence of any skin impairments to the resident's feet. Further review revealed the resident's nails toenails were cut. During surveyor observations and interviews with the resident on 6/8/2026 at 11:46 AM, 6/9/2026 at 12:47 PM, and 6/10/2026 at approximately 8:30 AM, the resident complained of foot pain and stated that s/he had pulled his/her toenail off a couple of weeks ago. Observations revealed his/her left great toe without a toenail and a dark, discolored area where the nail should be. Additional observations revealed a dark colored, raised area on the top of the resident's right third toe. Record review failed to reveal evidence that the above-mentioned impairments of the resident's toes were identified by the facility, or that a treatment was in place. Review of a podiatry exam dated 4/8/2026, revealed the resident was an increased risk of infection and seen for diabetic foot care. Further review revealed that the resident's left and right great toenails were thick and yellow, and the right and left 2nd through 5th toenails were elongated. Additional review failed to reveal any toenails were missing or any open areas were noted. During a surveyor interview and observation on 6/10/2026 at 8:59 AM, with Nursing Assistant (NA), Staff I, he revealed that he provided foot care for the resident on 6/9/2026 and did not notice any new areas on the resident's feet. At this time Staff I and the surveyor observed the resident's feet with a left great toenail missing with dark discoloration to the area and a dark area on the top of the resident's right 3rd toe. Staff I stated that the impairments on the resident's feet had been there for approximately a week and that the nurse is aware of the areas. During a surveyor interview and observation on 6/10/2026 at 9:03 AM, with Licensed Practical Nurse, Staff B, she indicated that the resident frequently picks at his/her skin and that the last time she assessed the resident's feet they were rough and dry. After observing the resident's feet in the presence of the surveyor, Staff B revealed that the resident's left great toe was always discolored but she was unable to recall if s/he had a toenail. Additionally, she revealed that she was unaware of the dark, raised area to the resident's 3rd toe and that there was not a treatment in place for the area. Record review of the progress notes revealed the following: -6/10/2026- .assessments done to bilateral toes with left great toe discoloration due to no toe, right foot 3rd toe with dry blood, MD [name redacted] notified, and wound nurse assess area with this nurse. order for skin prep to right foot 3rd toe bid [twice a day]. -6/10/2026- .vashe wash [a wound cleanser] to right foot 3rd toe f/b [followed by] skin prep [a fast-drying sterile liquid that forms a protectant film on the skin] bid until healed. -6/11/2026- .resident's L [left] great toenail is missing. Nurse measured the scabbed area being 1.7 [centimeters-cm] by 1[cm]. Reported to Optum NP [Nurse Practitioner] New orders in place to monitor toe for s/sx [signs and symptoms] of infection [times] 1 week and then reassess, continue with tx [treatment] to R [right] 3rd toe [times] 1 week and reassess. obtain Podiatry consult. During a surveyor interview on 6/11/2026 at 10:58 AM, with Optum NP, Staff J, she revealed (continued on next page)		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that she last assessed the resident on 5/28/2026 and had not been aware of any skin impairments to the resident's toes. She further indicated that she would assess the resident's skin that day. Record review of the Optum NP note dated 6/11/2026, revealed the resident was assessed and the left great toe was noted to be missing a toenail with a very short nail at the base, black discoloration in place of the nail, and blanchable redness to the left heel. Further review revealed the right 3rd toenail was missing with dark dried drainage at the base, which appeared to be dried blood and a healed dry brown scab on the right heel. Additional review revealed a plan for treatment which included; applying vashe wash and skin prep to the right 3rd toe as ordered, monitoring for skin infections, obtaining a podiatry consult, offloading both heels, and apply skin prep to bilateral heels daily. During a surveyor interview on 6/11/2026 at 12:06 PM, with the Director of Nursing Services, she revealed that she would have expect the NA to notify the nurse when a new skin impairment was observed and the provider would be notified. Additionally, she could not provide evidence that treatment and care was provided to maintain good foot health as evidence by the new skin impairments to the resident's toes which had not been assessed and treated timely.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415079	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Cedar Haven Operations Holding LLC Valley View Hea		STREET ADDRESS, CITY, STATE, ZIP CODE 4 St Joseph Street Woonsocket, RI 02895	
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F 0689 Level of Harm - Minimal harm or potential for 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 surveyor observations, clinical record review, and staff interview, the facility failed to complete quarterly smoking assessments for 2 of 5 residents reviewed who smoke, Resident ID #s 79 and 116. Findings are as follows: Review of a facility policy titled Smoking dated 5/15/2025, states in part, .To ensure that the resident that smokes is able to do so safely and in a manner that protects the safety and rights of others. Residents who request to smoke are assessed for their capability of safely handling the smoking materials, effectively lighting the cigarette, hold the cigarette while smoking and safely extinguish the cigarette. An assessment will be completed upon any resident who expresses an interest in smoking. completed quarterly, or when there is a change in mental and/or physical status. 1. Record review revealed Resident ID #79 was admitted to the facility in October of 2025 with a diagnosis including, but not limited to, chronic obstructive pulmonary disease (COPD). Record review revealed a Smoking - Safety Screen was completed on 10/24/2025. Further review revealed the resident required assistance to go to the smoking area and supervision while smoking. Record review failed to reveal evidence of a care plan relative to smoking or implementation of any related safety interventions. Record review failed to reveal evidence any quarterly smoking assessments following the above-mentioned admission assessment, indicating two assessments were not completed, as required. During a surveyor interview on 6/11/2026 at 12:06 PM, with the Director of Nursing Services (DNS), she revealed that she would expect smoking assessments to be completed quarterly and smoking care plans in place. 2. Record review revealed Resident ID #116 was initially admitted to the facility in August of 2020 and readmitted to the facility following a hospitalization in June of 2026 with diagnoses including, but not limited to, COPD, dementia, and weakness. Review of the Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 10 out of 15, indicating moderately impaired cognition. Record review of a care plan initiated 7/21/2021 revealed the resident is a supervised smoker. Record review of the progress notes revealed the resident was admitted to the hospital on [DATE] with the diagnosis of sepsis. Further review revealed the resident was readmitted to the facility on [DATE]. Record review of a provider note, with a service date of 6/5/2026, revealed the resident had bilateral upper extremity tremors that were chronic but worsening and affecting his/her activities of daily living. Record review revealed a Smoking-Safety Screen dated 5/16/2025, indicating that the resident required supervision when smoking. Further record review failed to reveal any quarterly smoking assessments were completed following the above-mentioned assessment until 5/8/2026, indicating in three quarterly assessments were not completed, as required. Record review of a Smoking-Safety Screen dated 5/8/2026 revealed the resident was safe to smoke without supervision. During a surveyor observation on 6/9/2026 at 2:12 PM, Resident ID # 116 dropped his/her lit cigarette out of his/her hand twice and required assistance from staff to pick it up. Review of a Smoking-Safety Screen dated 6/9/2026 at 2:38 PM, after the surveyor observation, revealed the resident required a smoking apron and supervision for safety while smoking due to a decrease in physical mobility and strength. During a surveyor interview on 6/10/2026 at 9:59 AM, with Licensed Practical Nurse, Staff K, he revealed that smoking assessments should be completed quarterly, if there is a change in the resident's status, or if an incident occurs. Additionally, he stated that he could not locate any completed quarterly smoking assessments between 5/16/2025 and 5/8/2026. During a surveyor interview on 6/10/2026 at 11:27 AM, with the DNS, she could not provide evidence quarterly smoking assessments had been (continued on next page)		

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed between 5/16/2025 and 5/8/2026. Additionally, she acknowledged that a smoking assessment had been completed on 6/9/2026 and that the resident now requires a smoking apron for safety while smoking.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on clinical record review and staff interview, the facility failed to ensure that residents who are trauma survivors, receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents experiences, and preferences, in order to eliminate, or mitigate triggers that may cause re-traumatization of the resident, for 1 of 1 resident reviewed with a history of trauma, Resident ID #13. Findings are as follows:Record review revealed that the resident was readmitted to the facility in April of 2026 with diagnoses including, but not limited to, post-traumatic stress disorder (PTSD) and anxiety.Review of a Minimum Data Set assessment, Section I Active Diagnosis dated 4/20/2026, revealed PTSD and Anxiety.Review of a Psychiatric Evaluation and Consultation dated 4/7/2026 revealed an active diagnosis of PTSD.Record review failed to reveal evidence of a care plan for PTSD to mitigate triggers that may cause re-traumatization.During a surveyor interview on 6/10/2026 at 12:22 PM, with Social Worker, Staff L, she revealed that she was aware the resident had a diagnosis of PTSD from a previous admission but did not implement a care plan for the PTSD on his/her most recent admission because it was not listed on his/her most recent admission paperwork.During a surveyor interview on 6/11/2026 at 12:06 PM, with the Director of Nursing Services, she acknowledged that the resident has a diagnosis of PTSD and does not have a care plan in place.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **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 bed rails were used only when assessed, clinically indicated, and implemented in accordance with the resident's needs for 2 of 2 residents reviewed with bed rails, Resident ID #s 124 and 158. Findings are as follows: Review of a facility policy titled, Side Rail Use last revised 8/29/2023, states in part, . This facility recognizes the potential for the hazard of entrapment related to side rail use. It is our policy therefore, to eliminate or minimize the use of side rails. Prior to installing side rails, we will utilize appropriate alternatives. If side rails are used an appropriate assessment as to the risk for entrapment and safety will be done. Informed consent will be obtained. 1. Record review revealed Resident ID #124 was admitted to the facility in January of 2026 with a diagnosis including, but not limited to, Huntington's disease (a disorder that causes certain nerve cells in the brain to stop working properly. It leads to mental deterioration and loss of control over major muscle movements). Record review of the Quarterly Minimum Data Set assessment (MDS) dated [DATE], revealed a Brief Interview for Mental Status score of 00 out of 15, indicating severe cognitive impairment. Further review revealed that s/he required substantial to maximal assistance for bed mobility. Review of a facility assessment titled, Side Rail Assessment and Consent form 2.0- V2 dated 4/13/2026, states the following, . Medical condition to require the use of side rails: none. Reason for side rail usage: none. Resident can demonstrate proper use of device: No. Type of rails to be used: none. Risk and Benefits: N/A (Not Applicable). Surveyor observations on 6/8, 6/9, 6/10, and 6/11/2026 revealed the resident has bilateral bed rails. During a surveyor interview on 6/10/2026 at 11:17 AM, with the Director of Nursing Services (DNS), she acknowledged that Resident ID #124 has side rails. She further revealed that she would have expected the bed rail assessment to be completed with the appropriate consent. 2. Record review revealed Resident ID #158 was admitted to the facility in February of 2026 with a diagnosis including, but not limited to, Alzheimer's disease. Record review of the Quarterly MDS dated [DATE], revealed a Brief Interview for Mental Status score of 00 out of 15, indicating severe cognitive impairment. Further review revealed that s/he was dependent on staff for bed mobility. Review of a facility assessment titled, Side Rail Assessment and Consent form 2.0- V2 dated 6/7/2026, states the following, . Medical condition to require the use of side rails: Alzheimer's disease. Reason for side rail use: Boundary Limitations. Resident can demonstrate proper use of device: No. Type of rails to be used: Two half side rails. Frequency of use: daily . Surveyor observations on 6/8, 6/9, 6/10, and 6/11/2026 revealed the resident has bilateral bed rails. During a surveyor interview on 6/10/2026 at approximately 10:49 AM, with the Unit Manager, Staff M, she revealed that the resident has bilateral side rails because the family requested them. She further revealed that the resident was dependent on staff for bed mobility and could not independently utilize the bed rails and acknowledged that the physician's order did not accurately reflect the resident's use of the devices. She further acknowledged that the facility would not typically implement bed rails for a resident who is unable to use them. During a surveyor interview on 6/10/2026 at 11:17 AM, with the DNS, she revealed that she was unsure what the meaning of boundary limitations in the side rail assessment. She further acknowledged that the order for bed rails is not accurate and that the resident cannot use them appropriately.		

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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 interviews, the facility failed to ensure each resident's medication regimen is free from a medication error rate of 5% or greater. Based on 27 opportunities for errors observed during the medication administration task, 2 errors occurred, resulting in an error rate of 7.41% affecting Resident ID #s 128 and 133. Findings are as follows: Review of a facility policy titled, Medication Administration dated 10/11/2017, states in part, .Medications ordered to be given according to specific parameters must reflect the results of testing, i.e. [in other words] blood pressure. Prepare medications for the resident following the instructions on the MAR [Medication Administration Record]. 1a. Record review revealed Resident ID #133 has a physician's order to administer furosemide 40 milligrams, one tablet in the morning, for high blood pressure. Additionally, special instructions include blood pressure parameters to hold the medication if the resident's systolic blood pressure (top number) is less than 90 or if the diastolic blood pressure (bottom number) is less than 50. During a surveyor observation of the medication administration task on 6/9/2026 at 9:35 AM, with Licensed Practical Nurse (LPN) , Staff N, he failed to obtain the resident's blood pressure and was prepared to administer the resident's furosemide until he was stopped by the surveyor. During a surveyor interview immediately following the above observation with Staff N, he revealed that he had administered the resident another blood pressure medication at approximately 8:00 AM that morning and had assessed his/her blood pressure at that time. He revealed that he was using the same blood pressure reading that he obtained approximately 90 minutes earlier as his reference. Staff N indicated that he should be reassessing the resident's blood pressure immediately prior to administering the furosemide. Further, he revealed that it is his normal practice to not re-assess the resident's blood pressure and to use prior blood pressure readings. 1b. Record review revealed Resident ID #128 has a physician's order to administer Lactaid (a digestive enzyme) 3,000 units, one tablet, three times daily for lactose intolerance. During a surveyor observation of the medication administration task on 6/9/2026 at 10:26 AM with Certified Medication Technician, Staff O, he was observed to have administered one Lactaid tablet to the resident from the facility's house stock. Record review, upon completing the medication reconciliation for Resident ID #128, revealed the facility's house stock Lactaid tablets are 9,000 units per tablet. During a surveyor interview on 6/9/2026 at 1:23 PM with LPN, Staff N, he acknowledged that the facility's house stock Lactaid tablets are 9,000 units and the resident's order is to administer 3,000 units. Additionally, he revealed that the facility's house stock Lactaid tablets are the only Lactaid tablets that he uses to administer to the residents. During a surveyor interview on 6/9/2026 at 1:54 PM with the Director of Nursing Services, she revealed that she would expect staff to re-assess Resident ID #133's blood pressure at the time of his/her furosemide administration and for Resident ID #128 to have received the correct dose of Lactaid.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and staff interview, it has been determined that the facility failed to accurately maintain the resident's medical record in accordance with accepted professional standards and practices relative to 1 of 1 closed record missing a discharge summary, Resident ID #171. Findings are as follows: Record review revealed the resident was admitted to the facility in July of 2024 with diagnoses including, but not limited to, atrial fibrillation (irregular heartbeat) and diabetes. Record review of the progress note revealed a nursing entry indicating that the resident was found diseased in his room and pronounce dead at 7:50 PM on 3/16/2026. During a surveyor interview on 6/10/2026 at 12:41 PM, with Social Worker, Staff P, she was unable to provide evidence that a discharge summary was completed. During a surveyor interview on 6/10/2026 at 1:40 PM, with Medical Records, Staff Q, she was unable provide evidence that a discharge summary was completed. During a surveyor interview on 6/10/2026 at 2:39 PM and 6/11/2026 at approximately 12:00 PM, with the Administrator, she revealed that she would expect the discharge summary to be completed within 2-3 weeks or within 30 days and she was unable to provide evidence that a discharge summary had been completed.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on clinical record review, surveyor observation, and staff interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections and the use of Enhanced Barrier Precautions (EBP; refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO] that employs targeted gown and glove use during high contact resident care activities), for 2 of 2 residents reviewed with wounds, Resident ID #s 63 and 93, and for 1 of 1 resident reviewed with a Peripherally Inserted Central Catheter (PICC, a long, flexible, thin tube inserted through a vein in the upper arm and advanced into a large vein near the heart) Resident ID # 66. Findings are as follows: Review of a facility policy titled, Isolation dated 2/17/2025 states in part, Enhanced Barrier Precautions- This level of precaution expands the use of PPE [personal protective equipment] beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDRO [Multi Drug Resistant Organism] to staff hands and clothing. residents with chronic un-healing wounds or indwelling medical devices regardless of their MDRO colonization status will be on Enhanced Barrier Precautions for the duration of their stay or until the resolution of the wound or discontinuation of the indwelling medical device. Examples of high contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include. device care of use: central line. wound care: chronic. 1a. Record review revealed Resident ID #63 was admitted to the facility in December of 2025 with a diagnosis including, but not limited to, obesity. Record review revealed a Wound Evaluation and Management Summary dated 6/2/2026, indicating Resident ID #63 has the following wounds: -Stage II Pressure Ulcer to the right ischium (a pair of bones forming the back of the hip bone) measuring 0.9 centimeters (cm) X 1.5 cm X 0.1 cm with light serous drainage (a clear or yellow fluid that leaks out of a wound). -Stage II Pressure Ulcer to the left ischium measuring 0.5 cm X 0.9 cm X 0.1 cm with light serous drainage. Review of a physician's order for wound care to the right and left ischium dated 4/8/2026, revealed to apply triad mixed with Silvadene (an antibiotic) and cover with an island border gauze, 1 time per day and as needed. Review of a care plan dated 2/17/2026, revealed the resident has wounds and is on enhanced barrier precautions with an intervention including, but not limited to, gloves and gown donned prior to high-contact care activities. Surveyor observations on all days of the survey failed to reveal Resident ID #63 was on EBP. During a surveyor observation on 6/10/2026 at 9:23 AM, with Registered Nurse (RN), Staff R, she went into the resident's room to perform wound care. Staff R did not wear a gown during wound care. During a surveyor interview immediately following the above-observation, Staff R acknowledged that she did not wear a gown during wound care. Per Staff R she was unaware the resident was on EBP due to there being no signage outside of his/her room. During a surveyor interview on 6/10/2026 at approximately 10:30 AM, with the Infection Preventionist, she acknowledged that Resident ID #63 is not on enhanced barrier precautions, although, s/he has wounds. 1b. Record review revealed Resident ID #93 was admitted to the facility in September of 2023 with a diagnosis including, but not limited to, Alzheimer's disease. Record review revealed the following physician's orders: -cleanse right hand wound with wound spray, apply bacitracin and cover with small gauze, followed by kling wrap daily and as needed for soiling. -Cephalexin (antibiotic) oral tablet 250 milligrams two times a day for infection to right hand wound. Surveyor observations on all days of the survey failed to reveal evidence that the resident was on EBP. During a surveyor observation on 6/9/2026 at 12:20 PM, in the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	presence of Licensed Practical Nurse (LPN), Staff G, the resident was observed in the dining room with an exposed wound on his/her right hand with visible light-colored fluid drainage seeping from the wound. During a surveyor interview immediately following the above observation, Staff G acknowledged that the resident has a wound on his/her right hand that was draining. During a surveyor interview on 6/11/2026 at 9:35 AM, with RN, Staff S, she stated that she had changed Resident ID #93's dressing that day and did not wear a gown because she was unaware the resident was on EBP, as there was not any signage on the resident's door. During a surveyor interview on 6/11/2026 at 10:33 AM, with the IP, she revealed that Resident ID #93 should be on EBP due to his/her wound drainage. 2. Record review revealed that Resident ID #66 was admitted to the facility in January of 2026 with a diagnosis including, but not limited to, osteomyelitis (an infection in the bone) of the right foot and ankle. Review of a physician's order dated 5/22/2026, revealed the resident is on EBP due to a PICC line and a wound. Review of a care plan dated 3/16/2026 revealed the resident is on EBP due to wounds with an intervention including, but not limited to, gloves and gown donned prior to high-contact care activities. During a surveyor observation on 6/9/2026 at 11:04 AM, with Licensed Practical Nurse, Staff N, he was observed initiating antibiotic administration through the resident's PICC line without wearing a gown, as required. During a surveyor interview immediately following the above-observation, Staff N acknowledged that Resident ID #66 was on EBP and he should have worn a gown while accessing his/her PICC line. During a surveyor interview on 6/10/2026 at 12:30 PM with the IP she revealed that she would expect staff to wear a gown when accessing a resident's PICC line. During a surveyor interview on 6/10/2026 at approximately 11:30 AM with the Director of Nursing Services she was unable to provide evidence that staff utilized enhanced barrier precautions for Resident ID #s 63, 66, and 93, as required.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections relative to the pneumonia vaccine policy's failure to align with current guidelines, as recommended, by the Advisory Council on Immunization Practices (ACIP) and Centers for Disease Control and Prevention (CDC). Findings are as follows: Review of an undated facility policy titled, Resident Vaccination (Flu and pneumonia) states in part, .Vaccinations are to be provided in accordance with the most recent ACIP (Advisory Council on Immunization Practices) guidelines for these vaccinations. As of 2014, ACIP has recommended the following pneumonia vaccination schedule (Also follow CDC Vaccination for Elders guidelines): Persons [AGE] years of age or over who have never received a pneumonia vaccination should receive PCV13. According to current ACIP guidelines and the CDC, as of 2/25/2026 the pneumonia vaccine, PCV13, is no longer recommended to be administered as a pneumonia vaccine. During a surveyor interview on 6/10/2026 at 1:45 PM with the Infection Preventionist, she revealed that the above-mentioned facility policy is their most current and includes PCV13. Additionally, she acknowledged that their policy is not up to date with current guidelines. During a surveyor interview on 6/10/2026 at 1:50 PM with the Administrator, in the presence of the Director of Nursing Services, they were unable to provide evidence that their facility policy relating to pneumonia vaccination aligns with current guidelines.		