

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER St Antoine Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 10 Rhodes Avenue North Smithfield, RI 02896	
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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure that the attending practitioner was immediately notified of a significant change in a resident's physical and clinical status for 1 of 1 resident reviewed with a change in condition, Resident ID #1. Specifically, nursing staff failed to notify the provider of Resident #1's acute decline in functional mobility (digressing from a 2-assist walker transfer to requiring the use of a mechanical lift for transfers) and multiple clinical manifestations of unmanaged pain (wincing, grimacing, heavy lateral leaning, and pointing to his/her right lower extremity) following consecutive falls on 6/16/2026 and 6/17/2026. Findings are as follows: Record review of a community reported complaint submitted to the Rhode Island Department of Health on 6/24/2026 alleges in part, that Resident ID #1 fell on 6/17/2026 and was not provided with any follow up care for 5 days. On day 5, x-rays were obtained and they indicated a fracture. The complaint further alleges the resident was grimacing in pain prior to receiving the x-rays. Record review revealed Resident ID #1 was admitted to the facility in June of 2026 with diagnoses including, but not limited to, dementia and history of falling. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed that a Brief Interview for Mental Status (BIMS) was not attempted because the resident was rarely/never understood. The MDS revealed that the resident required assistance with all activities of daily living (ADLs). Review of a physical transfer assessment dated [DATE] established that the resident's baseline transfer status was a 2-person assist with the use of a rolling walker. Review of the progress notes revealed the following entries: -6/16/2026 the resident was intercepted wandering into another resident's room, turned, and slid onto the floor. -6/17/2026 the resident was found lying on the floor in the common area. The provider was notified of the fall, and laboratory tests were ordered. Record review revealed that no diagnostic imaging was ordered on 6/17/2026, per the physician's request. Review of the Physical Therapy Treatment Encounter Note revealed the following: -6/17/2026 Physical Therapy (PT) documented, prior to the resident's fall later that day; there were no signs or symptoms of pain via verbal or non-verbal communication. -6/18/2026 the Nursing Assistant (NA) and floor nurse reported the resident had difficulty with mobility and getting out of bed. During the PT assessment, the resident was unable to take steps forward or pivot. The resident's family representative reported to staff that the resident may be having pain and is unable to communicate that. PT documented that the resident appeared to be uncomfortable. Record review failed to reveal evidence that nursing staff notified the provider of the resident's inability to ambulate or concerns relative to pain. -6/19/2026 PT documentation revealed the resident exhibited visible facial grimacing during right lower extremity (RLE) movement and pointed directly to his/her right knee. PT downgraded the resident's transfer status from a 2-person walker transfer to a mechanical lift. PT staff documented that they provided education to the floor nurses and NAs (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER St Antoine Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 10 Rhodes Avenue North Smithfield, RI 02896	
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 0580 Level of Harm - Actual harm Residents Affected - Few	regarding the resident's repeated facial grimacing during RLE manipulation. The representative again reported that the resident is not himself/herself today. Record review failed to reveal evidence that nursing staff notified the provider of the transfer status downgrade or the localized non-verbal pain cues.-6/21/2026 PT notes revealed the resident presented as very rigid, stood with a heavy left lateral lean, and refused to bear weight.Review of a nursing progress note dated 6/21/2026 (four days after the fall on 6/17/2026 and three days after his/her acute mobility decline) revealed that the Nurse Practitioner (NP) was updated regarding the resident's increased pain and concerns with mobility. The NP subsequently ordered an X-ray of the hip and lumbar spine.Record review revealed the ordered X-ray was not obtained until 6/22/2026.PT documentation on 6/22/2026 noted the resident was in escalating pain, wincing/grimacing and pointing to the RLE and pelvic area.Review of the Medication Administration Record (MAR) for June 2026 revealed the resident had an active, scheduled order for Tylenol Oral Tablet 325 milligram (mg) give 2 tablets by mouth two times a day for osteoarthritis pain, which was documented as administered as ordered. Despite receiving this scheduled baseline medication for pain, the record showed that the resident was experiencing breakthrough orthopedic pain following the fall. For this breakthrough pain, the resident only received two as-needed doses of Tylenol 650 mg throughout the entire post-fall period (one dose on 6/18 for a recorded pain score of 3/10, and one dose on 6/22 for a recorded pain score of 5/10).Record review failed to reveal evidence of provider notification regarding the failure of the current pain regimen to control the residents' acute symptoms.The X-ray completed on 6/22/2026 revealed a right hip fracture. Review of hospital documentation dated 6/23/2026 revealed the resident was transferred and admitted for orthopedic surgery. The hospital physician noted: Resident had a fall on 6/17/2026 . delayed imaging shows neck of femur fracture (a break in the upper part of the right thigh bone just below the hip joint).During a surveyor interview on 7/9/2026 at 12:36 PM, with Licensed Practical Nurse, Staff A, she revealed that the resident was able to answer simple yes or no questions. She further revealed that the resident would verbally deny pain but would be grimacing while denying it.During a surveyor interview on 7/9/2026 at 12:45 PM with the Unit Manager, he revealed that he could not remember if the acute pain or a change in mobility status was ever reported to the provider. He was unable to provide any documentation or evidence that the provider was notified of the change in the resident's status.During a surveyor interview with the Director of Nursing Services on 7/9/2026 at 12:52 PM, she was unable to provide evidence that the provider was notified of Resident #1's significant change in condition between 6/18/2026 and 6/21/2026.The facility failed to recognize Resident ID #1's loss of baseline ability to step or pivot, repeated nonverbal signs of pain during limb movement, and new dependence on a mechanical lift as a significant change in physical status requiring immediate provider notification. As a result, the resident remained with an unstable fractured hip for four days without timely medical evaluation or effective pain management, resulting in actual physical harm.		