STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415110	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Grove Health Care Center	560 Cumberland Hill Road 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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415110	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Grove Health Care Center	560 Cumberland Hill Road 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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, it has been determined that the facility failed to keep a resident free from physical abuse, for 1 of 4 residents reviewed, Resident ID #1.Findings are as follows:Review of a facility reported incident submitted to the Rhode Island Department of Health on 7/22/2025 revealed in part, Resident ID #2 (the perpetrator) was observed walking over to Resident ID #1 (the victim), in the dining room, and grabbed his/her left wrist, twisted it back and pulled his/her hair. Further review revealed Resident ID #2 was transferred to the hospital for a psychiatric evaluation and a STAT (immediate) X-ray was ordered for Resident ID #1.Review of a facility policy titled, RESIDENT ABUSE, NEGLECT, MISTREATMENT AND MISSAPROPRIATION PREVENTION, dated April 2015 states in part, .Each resident has the right to be free from abuse, neglect, mistreatment.'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.According to the State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, last revised 4/25/2025, willful means that the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm.Record review revealed Resident ID #1, the victim, was admitted to the facility in May of 2025 with a diagnosis including, but not limited to, Alzheimer's disease. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) was unable to be completed, as the resident is rarely/never understood, indicating severe cognitive impairment.Record review revealed Resident ID #2, the perpetrator, was admitted to the facility in July of 2025 with a diagnosis including, but not limited to, severe dementia with agitation.Review of an MDS assessment dated [DATE] revealed a BIMS was unable to be completed, as the resident is rarely/never understood, indicating severe cognitive impairment. Further review revealed Resident ID #2 displayed wandering and physical behavioral symptoms directed towards others, 1 to 3 days, during the 7-day look back period.Record review of a care plan last revised on 7/24/2025, for Resident ID #2, revealed s/he has a history of violent and aggressive behaviors and was involved in an altercation with a resident on 7/15/2025 and with Resident ID #1 on 7/22/2025. Record review for Resident ID #2 revealed a progress note dated 7/22/2025 which revealed Resident ID #2 was in the dining room when s/he approached Resident ID #1, grabbed him/her by the left wrist, twisted his/her left wrist, and pulled his/her hair. Further review revealed Resident ID #2 was placed on a 1 to 1 with staff for safety and was sent to the hospital for a psychiatric evaluation.Further record review for Resident ID #2 revealed a progress note dated 7/23/2025 which revealed s/he was admitted to geriatric psych at the hospital, on an emergency certification (a process that allows a physician to apply for the certification of a person who is believed to need immediate care due to psychiatric disability).Additional record review for Resident ID #2 revealed that earlier in the day on 7/22/2025, at approximately 2:21 PM, staff were attempting to redirect him/her from another resident's room, when Resident ID #2 responded by striking a Nursing Assistant in the chest.Record review for Resident ID #1 revealed the following progress notes: - 7/22/2025 at 9:56 PM, revealed Resident ID #1 was eating dinner in the dining room, when Resident ID #2 approached him/her, grabbed him/her by the left wrist, twisted his/her left wrist, and pulled his/her hair. Further review revealed Resident ID #1 did not do anything to provoke this incident. Additionally, upon initial assessment, no injuries were noted, however Resident ID #1 was administered Tylenol, 650 milligrams for left wrist pain, and a STAT X-ray of his/her left wrist was ordered, to rule out injury.- 7/23/2025 at 7:45 AM, revealed Resident ID #1 was noted to be guarding his/her left wrist/hand area and a bruise measuring approximately 1.5 x 2 inches was noted to be on his/her right hand.- 7/23/2025 at 10:39 PM, revealed that the following the physical altercation with Resident ID #2, the resident sustained a wrist fracture and was transported to the hospital.- 7/24/2025 at 1:22 AM, revealed Resident ID #1 returned to the facility with a diagnosis of a left distal radial fracture (wrist fracture) and a volar splint (a medical device used to immobilize and support the wrist and hand, particularly for injuries or conditions affecting the palm or volar aspect of the hand) was applied, with instructions to follow up with an orthopedic surgeon.During a surveyor interview on 8/6/2025 at 10:58 AM, with Nursing Assistant, Staff A, she revealed that she was in the dining room and witnessed Resident ID #2 approach Resident ID #1 at his/her table and attempted to take his/her food. She revealed that when she attempted to redirect Resident ID #2 away from Resident ID #1, Resident ID #2 reacted by grabbing Resident ID #1's wrist and twisted it, causing Resident ID #1 to scream. Further, she revealed that it took three staff members to separate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415110	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Grove Health Care Center	560 Cumberland Hill Road 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 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 surveyor observation, record review, and staff interview, it has been determined that 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 for a splint, Resident ID #1.Findings are as follows:Review of a facility policy titled, SPLINTS/ORTHOTICS/PROSTHETICS, dated April 2015 states in part, .Upon admission/readmission, and at least every shift, all residents with a splint.will have the affected extremity monitored for circulation, motion and sensation [CSM] as well as any signs of edema [swelling], redness, irritation, or pressure areas potentially caused by the device.Nursing staff will remove the device and notify the physician and the rehabilitation department if the resident has actual or potential alteration in skin integrity that may have been caused by the device.Document evaluations and notify MD [medical doctor] of any abnormalities.Record review revealed Resident ID #1 was admitted to the facility in May of 2025 with a diagnosis including, but not limited to, Alzheimer's disease.Record review of progress notes revealed the resident sustained a distal radial (wrist) fracture of his/her left hand, following a physical altercation with another resident on 7/22/2025.Further record review revealed the resident was transferred to the hospital on 7/23/2025 to obtain a splint for his/her left wrist and returned on 7/24/2025 with a volar splint (a medical device used to immobilize and support the wrist and hand, particularly for injuries or conditions affecting the palm or volar aspect of the hand).Record review failed to reveal evidence of physician's orders relative to monitoring for CSM and skin integrity, each shift, per the facility policy.During a surveyor observation on 8/6/2025 at 12:55 PM, the resident was observed with a volar splint, wrapped in an ACE bandage, on his/her left wrist.During surveyor interviews on 8/6/2025 at 12:30 PM and 12:52 PM, with Licensed Practical Nurse, Staff B, she acknowledged that there are not any physician's orders in place to monitor for CSM and skin integrity, relative to the splint, and indicated that there should be. During surveyor interviews on 8/6/2025 at 1:07 PM and 1:36 PM, with the Director of Nursing Services, she revealed that the resident sustained a wrist fracture on 7/22/2025, requiring a volar splint and indicated that the splint is to remain in place until the resident is seen by an orthopedic surgeon on 8/12/2025. She revealed that she would have expected physician's order to be in place relative to the usage of the splint and for monitoring skin integrity and CSM. During a surveyor interview on 8/6/2025 at 1:39 PM, with the resident's provider, she acknowledged that there are no current orders in place to monitor for CSM and skin integrity relative to the splint and indicated that there should be an order to monitor for skin integrity, but would not confirm if an order should be implemented relative to CSM, as indicated in the facility's policy. Record review revealed the following physician's orders that were implemented on 8/6/2025, 13 days after the resident returned to the facility with a splint, and after it was brought to facility's attention by the surveyor:- Monitor left upper extremity and left lower extremity for CSM, every shift, for left wrist fracture and soft splint.- Monitor skin integrity of left hand, wrist and arm, every shift, for left wrist fracture and soft splint for 30 days.