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	12/10/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to adhere to its established bowel management protocol by not initiating timely interventions after 9 consecutive shifts without a bowel movement, failing to notify the provider of medication refusal and a new diagnosis of constipation, and neglecting to reassess and update the care plan. These failures resulted in prolonged fecal impaction, hospitalization, and contributed to the Resident's clinical deterioration and death. This deficient practice was identified in 1 of 3 residents reviewed for bowel management, Resident ID #1. Findings are as follows:Review of a community reported complaint submitted to the Rhode Island Department of Health on 12/8/2025, alleged that while Resident ID #1 was at the facility, the facility failed to address the resident's constipation. It further alleged that the resident was hospitalized related to this failure.Review of a facility policy titled, BOWEL EVACUATION PROTOCOL, dated March 2016, revealed, The facility has the responsibility to ensure that each resident develops regular bowel habits with or without cathartic [laxative] assistance. The purpose is to prevent impaction and incontinence promote psychological and social well-being. Procedure.if the resident has had no bowel movement for 9 consecutive shifts, begin the bowel protocol on the 3:00 p.m. - 11:00 p.m shift.The bowel protocol is to give Milk of Magnesia (MOM) on the 3:00 p.m. - 11:00 p.m. shift. If the MOM is ineffective, then the resident is to receive a Bisacodyl [laxative] suppository on the 11:00 p.m. to 7:00 a.m. shift. If the Bisacodyl suppository is ineffective, then the resident is to receive a Fleet enema on the 7:00 a.m. to 3:00 p.m. shift. Record the results of the Bowel Protocol on the reverse side of the M.A.R [Medication Administration Record] and/or in the Nurses Notes. Notify the physician if the Bowel Protocol is ineffective.Record review revealed Resident ID #1 was admitted to the facility in October of 2025 with a diagnosis including, but not limited to, acute kidney failure. Additionally, the resident was discharged from the facility on 10/22/2025, to an acute care hospital.Review of the resident's bowel movement report revealed that s/he went 15 consecutive shifts from 10/15/2025, through the end of day on 10/19/2025, without a bowel movement. The resident went 6 additional shifts after the bowel protocol should have been initiated without intervention. Record review failed to reveal evidence that the bowel protocol was initiated or followed on the 9th consecutive shift, per the facility policy. The facility failed to begin the bowel protocol on the 3:00 p.m. - 11:00 p.m shift, beginning with the initiation of Milk of Magnesia (MOM) on the 3:00 p.m. - 11:00 p.m. shift. Followed by administering the Bisacodyl suppository, followed by a fleet if needed. Record review revealed on 10/19/2025, the 14th shift without a bowel movement, Certified Medication Technician (CMT), Staff A, attempted to administer the resident MOM, which the resident refused. Further review failed to reveal evidence that the refusal of the MOM was reported to the provider for further instruction or a change in the bowel management protocol. The facility failed to notify the physician that the bowel protocol was unable to be followed or was ineffective as stated in the facility policy. Record review revealed on 10/20/2025, the resident was then sent to an acute care hospital for stroke-like symptoms. Further review revealed the resident returned the same day from the hospital with a new diagnosis of constipation.Record review of the acute care hospital summary dated 10/20/2025 revealed, the resident was found to have abdominal distention and constipation but no abdominal pain.Record review failed to reveal evidence that the provider was notified that the resident returned on 10/20/2025 with a new diagnosis of constipation to allow for an adjustment to the resident plan of care to manage his/her constipation, although the provider was contacted on 10/21/2025 by Registered Nurse, Staff B.Record review of the progress notes for 10/22/2025 revealed, at 12:19 PM, the resident presented with a distended abdomen that was tender to the touch and MOM was administered at this time and a message was left with the provider. Additionally, at 4:56 PM, an order was provided by the provider to obtain a STAT (immediate) kidney, ureter, and bladder (KUB- an abdominal x ray). Further review of the progress notes revealed, documented at 6:44 PM that the resident had increased pain upon palpation (touching) of the abdomen, which at this time is extremely distended with bowel sounds only in the left upper quadrant of the abdomen (bowel sounds should be heard in all four quadrants of the abdomen). The resident was then sent to the hospital via emergency medical services.Further record review of a progress note dated 10/23/2025 revealed that the resident was admitted to the acute care hospital at 1:37 AM with a diagnosis of constipation.Review of the acute care hospital summary from 10/22/2025 through 10/23/2025 revealed, the resident came to the emergency department with complaints of constipation. A CT scan was completed with finding suggestive of