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	06/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adviniacare Oakland Grove LLC	560 Cumberland Hill Road Woonsocket, RI 02895

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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 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. Based on clinical record review, surveyor observation, and resident and staff interviews, the facility failed to immediately consult with the physician when a resident's condition significantly changed or when treatment required alteration for 2 of 2 residents reviewed, Resident ID #1 and #5. The facility failed to notify the practitioner of Resident ID #1's worsening respiratory status, fever, lethargy, and labored breathing while receiving hospice services, and failed to obtain a physician order or notify the practitioner regarding Resident ID #5's urinary retention requiring catheterization. These failures had the potential to delay medical evaluation and treatment and resulted in actual harm for Resident ID #5, who required hospitalization for urinary retention. Findings are as follows: Review of a facility policy titled, Physician Services dated 10/2022 states in part, It is the policy of the facility to ensure the medical supervision of a resident's care during their stay, orders for immediate care and needs are met by a physician. 1. Review of a facility policy titled, Hospice Services states in part, .When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and the resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. Record review revealed that Resident ID #1 was admitted to the facility in June of 2026 with diagnoses including, but not limited to, pneumonia and respiratory failure. Record review revealed that Resident ID #1 was admitted to Hospice Services on 6/10/2026 with a diagnosis of protein calorie malnutrition. Review of a Visit Notes-Hospice dated 6/10/2026 authored by Hospice Registered Nurse (RN), Staff I, revealed the resident was admitted to hospice services and that s/he is alert and oriented to person, place, and time. Additionally, Staff I, revealed that the resident is going outside to smoke 8-10 cigarettes a day. Further review revealed vital signs including, but not limited to, temperature of 98.8 degrees Fahrenheit (normal is 97-99 degrees Fahrenheit), respirations of 28 breaths per minute (normal 16-20 breaths per minute), and a heart rate of 105 beats per minute (normal 60-100 beats per minute). Review of a Visit Notes- Hospice dated 6/12/2026 authored by Hospice RN, Staff J, revealed the resident has an elevated temperature of 101.1 degrees Fahrenheit, a heart rate 114-122 beats per minute and respirations of 38-42 breaths per minute. Additionally, the note revealed the resident is minimally responsive with increased lethargy and labored breathing. Review of a Visit Notes- Hospice dated 6/13/2026 authored by Hospice RN, Staff K, revealed the resident had an elevated temperature of 102.1 degrees Fahrenheit, a heart rate of 116 beats per minute and respirations of 32 breaths per minute. Additionally, the resident was noted to be lethargic, pale and lying in a fetal position in the bed. Record review failed to reveal evidence that the resident's change in condition including worsening vital signs, increased lethargy, and labored breathing was reported to a provider on 6/12/2026 or 6/13/2026. During a surveyor interview on 6/16/2026 at 10:32 AM with Nurse Practitioner (NP), Staff L, she revealed that she spoke to the staff on 6/12/2026 regarding not having Morphine (a narcotic medication) to administer to the resident. Additionally, she revealed that the facility staff did not communicate to her the resident's change in condition including that s/he had a fever and other worsening symptoms. 2. Record review revealed that Resident ID #5 was admitted to the facility in November of 2024 with diagnoses including, but not limited to, dementia and anxiety. Review of a progress note dated (continued on next page)

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

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F 0580 Level of Harm - Actual harm Residents Affected - Few	6/12/2026 revealed that Resident ID #5 was complaining of abdominal pain and a previously obtained urine specimen was sent to the laboratory for urinalysis and new orders were obtained for blood work to be completed on 6/13/2026. Review of a progress note dated 6/13/2026 authored by RN, Staff M states in part, C/o [complained of] lower abdominal cramp/discomfort. Upon assessment and palpation supra-pubic distention noted. Writer emptied 800cc [cubic centimeter. 1cc is equal to 1 milliliter of fluid] of amber colored Urine from the bladder, Resident verbalized relief. Record review failed to reveal evidence of a physician's order for Resident ID #5 to be catheterized for urinary retention. Further review failed to reveal evidence that a provider was made aware of the catheterization or that the resident retained 800 cc of urine on 6/13/2026. During a surveyor observation and interview on 6/16/2026 at 12:41 PM, Resident ID #5 was lying in bed with only a shirt and brief on with his/her abdomen exposed. The resident's abdomen appeared distended. Resident ID #5 revealed that s/he was not feeling well and that his/her stomach was upset. During a surveyor interview on 6/16/2026 at 1:06 PM via telephone with NP, Staff N, he revealed that he did not give an order to catheterize Resident ID #5 for urinary retention and that he had not been notified that the resident retained 800 cc of urine on 6/13/2026. Per Staff N, he was working up Resident ID #5 for constipation. Review of a progress note dated 6/16/2026 revealed Resident ID #5 was yelling out in pain, and his/her abdomen was noted to be distended and firm. Additionally, Resident ID #5 was transferred to the hospital for further treatment. Review of the emergency room documentation revealed that the resident had been complaining of abdominal pain for 4 days and has abdominal distention. Additionally, the staff report s/he was screaming in pain. Review of the Hospital admission Documentation revealed the resident was admitted to the hospital with a primary diagnosis of urinary retention. During an interview on 6/17/2026 at 7:31 AM, RN Staff M acknowledged that there was no physician order to catheterize Resident ID #5 on 6/13/2026. She further stated that she did not notify the provider that 800 cc of urine was obtained during the catheterization and was unable to provide evidence that the resident's change in condition had been reported to the provider. During a surveyor interview on 6/17/2026 at 8:05 AM with the Director of Nursing Services (DNS) she revealed that she would have expected staff to obtain an order for catheterization and to report urinary retention to the provider. Additionally, the DNS was unable to provide evidence that the facility immediately consulted with the resident's physician when there was a need to commence a alter treatment significantly for Resident ID #s 1 and 5. The facility's failure to immediately consult with the physician regarding significant changes in condition and the need to alter treatment prevented timely practitioner assessment and intervention. As a result, Resident ID #5 experienced ongoing abdominal pain, urinary retention, and deterioration in condition requiring hospitalization. Additionally, Resident ID #1 experienced worsening respiratory distress, fever, and lethargy without evidence of physician notification or evaluation. These failures placed residents at risk for adverse outcomes and demonstrate the facility's failure to ensure appropriate physician involvement in resident care. Cross Reference F 684 and F 755

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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. Based on surveyor observation, clinical 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 following physician's orders for 1 of 1 resident observed for enteral nutrition tube feeding, (a delivery of nutrition into the stomach or small intestine via an enteral access device), Resident ID #2.Findings are as follows:Review of a facility policy titled Enteral Feedings last revised on 10/2022, states in part, .Position resident in semi-Fowler's position or according to plan of care.Record review revealed that Resident ID#2 was admitted to the facility in May of 2018 with diagnoses including, but not limited to, hemiplegia (complete paralysis of one side of the body) and hemiparesis (weakness or partial paralysis on one side of the body) due to cerebrovascular disease (a stroke) affecting the left non-dominant side and gastrostomy status (the medical state of a resident who has had a surgically created opening through the abdominal wall directly into the stomach to deliver nutrition or medications).Review of a physician's order dated 5/19/2026 revealed in part to elevate resident 30 -45 at all times during feeding and for one hour after gravity feeds .During a surveyor observation in the presence of Licensed Practical Nurse, Staff P, on 6/16/2026 at 12:45 PM, Resident ID #2 was observed lying in bed with the head of bed less than 30 elevated while receiving his/her enteral feed. The resident was in a fetal position. Staff P attempted to raise the head of the bed but was initially unsuccessful. Staff P then plugged the bed into the wall and was able to control the head of the bed height.During a surveyor interview immediately following the above-mentioned observation, Staff P acknowledged that the resident's head of the bed was not at the ordered height and should have been.During a surveyor interview conducted on 6/17/2026 at 10:27 AM, the Director of Nursing Services acknowledged that the resident's physician order required the head of the bed to be elevated and stated that staff were expected to ensure the order was consistently implemented.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on clinical record review and staff interview, the facility failed to provide care and services in accordance with the resident's physician-approved hospice plan of care for 1 of 1 resident reviewed receiving hospice services, Resident ID #1. Specifically, the facility failed to ensure timely administration of physician-ordered Morphine Sulfate for the management of pain and shortness of breath despite repeated hospice recommendations, worsening clinical symptoms, and the medication being available within the facility. As a result, Resident ID #1 experienced prolonged unmanaged pain and respiratory distress, including worsening lethargy, labored breathing, tachypnea (rapid shallow breathing), tachycardia (rapid heart rate), and fever. Findings are as follows:Review of a facility policy titled, Hospice Services states in part, .When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and the resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms.Record review revealed that Resident ID #1 was admitted to the facility in June of 2026 with diagnoses including, but not limited to, pneumonia and respiratory failure.Record review revealed that Resident ID #1 was admitted to Hospice Services on 6/10/2026 with a diagnosis of protein calorie malnutrition.Review of a Visit Notes-Hospice dated 6/10/2026 authored by Hospice Registered Nurse (RN), Staff I revealed the resident was admitted to hospice services and that s/he is alert and oriented to person, place, and time. Additionally, Staff I revealed that the resident is going outside to smoke 8-10 cigarettes a day. Further review revealed vital signs including, but not limited to, temperature of 98.8 degrees Fahrenheit (normal is 97-99 degrees Fahrenheit), respirations of 28 breaths per minute (normal are 16-20 breaths per minute), and heart rate of 105 beats per minute (normal is 60-100 beats per minute). Staff I made recommendations for care including, but not limited to, Morphine Sulfate (a narcotic) Concentrate 20 milligrams per milliliter (mg/ml), give 5 mg (0.25ml) by mouth every 8 hours scheduled for pain/shortness of breath and give 5 mg by mouth every two hours as needed for breakthrough pain or shortness of breath.Review of a progress note dated 6/10/2026 revealed the resident's physician approved all hospice recommendations including, but not limited to, Morphine Sulfate Concentrate 20 mg/ml, give 5 mg (0.25ml) by mouth every 8 hours scheduled for pain/shortness of breath and give 5 mg by mouth every two hours as needed for breakthrough pain or shortness of breath.Record review failed to reveal evidence of an active physician's order for Morphine Sulfate until 6/11/2026, although the order was received on 6/10/2026.Review of a Visit Notes-Hospice dated 6/11/2026 revealed Resident ID #1 had increased shortness of breath and had visible signs of respiratory distress. Additionally, the note revealed new hospice recommendations to increase the Morphine Sulfate Concentration 20 mg/ml to give 5 mg every 6 hours scheduled.Review of a progress note dated 6/11/2026 states in part, .Resident was visited by Hospice care team, all recommendations was approved by the provider.Review of the June 2026 Medication Administration Record (MAR) failed to reveal evidence that the scheduled or as needed Morphine Concentrate was administered on 6/11/2026.Review of a Visit Notes- Hospice dated 6/12/2026 authored by Hospice RN, Staff J revealed the resident has an elevated temperature of 101.1 degrees Fahrenheit, a heart rate of 114-122 beats per minute, and respirations of 38-42 breaths per minute. Additionally, the note revealed the resident is minimally responsive with increased lethargy and labored breathing. Further review revealed Hospice was requesting for the Morphine be administered as soon as it arrives.Review of the June 2026 MAR failed to reveal evidence that the scheduled or as needed Morphine Concentrate was administered on 6/12/2026.Review of a Visit Notes- Hospice dated 6/13/2026 authored by Hospice RN, Staff K revealed the resident had an elevated temperature of 102.1 degrees Fahrenheit, a heart rate of 116 beats per minute and respirations of 32 breaths per minute. Additionally, the resident was noted to be lethargic, pale and lying in a fetal position in the bed. Per Staff K the facility staff report that the resident does not have any Morphine Concentrate and that no pain medication had been administered since it was ordered. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Staff K revealed she spoke with the facility nurse, Staff O who then was able to get the medication from the facility's emergency supply and administer the Morphine at 2:15 PM.Review of the Electronic Medication Dispenser (EMD, a machine that is an automated medication dispensing system used in healthcare facilities to securely store, track, and manage medications) supply log identified Morphine Sulfate Concentrate as an available medication.Review of the EMD morphine inventory revealed the Morphine Sulfate Concentrate was not restocked in the inventory for use until 6/12/2026 at 2:31 PM.Record review revealed that although the medication was restocked in the EMD on 6/12/2026 at 2:31 PM, it was not administered to Resident ID #1 until 1:58 PM on 6/13/2026, as documented in the facility's Narcotic Log Book. This resulted in an additional delay of 23 hours and 27 minutes after the medication became available within the facility. During this period, the resident exhibited worsening clinical symptoms, including an elevated temperature of 101.1 degrees Fahrenheit, a heart rate ranging from 114 to 122 beats per minute, and respirations of 38 to 42 breaths per minute. Furthermore, the resident missed two scheduled doses that were due at 12:00 AM and 6:00 AM on 6/13/2026.During a surveyor interview on 6/17/2026 at 7:36 AM, Registered Nurse Staff M acknowledged working the overnight shift from 11:00 PM on 6/12/2026 to 7:00 AM on 6/13/2026. Staff M revealed that during the shift-to-shift report, she was informed by the outgoing nurse that the Morphine Sulfate Concentrate was unavailable in the EMD system. She stated that she did not check to see if the morphine sulfate concentrate was available in the EMD inventory prior to the scheduled 12:00 AM and 6:00 AM doses on 6/13/2026. Furthermore, Staff M revealed that she did not notify the attending provider regarding the unavailability of the medication to allow for any adjustments to the resident's plan of care required to manage pain and uncomfortable symptoms that were documented by the hospice provider.During a surveyor interview on 6/17/2026 at approximately 2:25 PM, the Director of Nursing Services (DNS) acknowledged that a review of the EMD automated medication dispensing supply logs identified Morphine Sulfate Concentrate as an available medication within the facility's inventory system but that the medication was initially unavailable. The DNS acknowledged that the EMD inventory records show the Morphine Sulfate Concentrate was restocked and physically available for nurse retrieval on 6/12/2026 at 2:31 PM. The DNS acknowledged that despite being restocked, the medication was not administered to the resident until 6/13/2026 at 1:58 PM. She was unable to provide evidence that the resident's plan of care between the facility, hospice agency and the resident/family were followed for managing pain and other uncomfortable symptoms.The facility failed to ensure the implementation of a physician-approved hospice plan of care intended to manage Resident ID #1's pain and respiratory distress. Despite hospice identifying worsening symptoms and requesting prompt administration of Morphine Sulfate, the resident did not receive the medication for approximately three days after it was ordered and for more than 23 hours after it became available within the facility. Staff failed to verify medication availability, administer the ordered medication, or notify the provider regarding missed doses and unmanaged symptoms. Consequently, Resident ID #1 experienced prolonged pain and respiratory distress, including worsening lethargy, labored breathing, tachypnea, tachycardia, and fever. These failures resulted in actual harm and were inconsistent with the resident's hospice plan of care and the facility's responsibility to provide necessary care and services to attain or maintain the resident's highest practicable well-being. Cross reference F 580 and F 755

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. Based on surveyor observation, staff interview, and clinical record review, the facility failed to ensure appropriate foot care was provided and arranged for 1 of 1 resident observed with overgrown toenails, Resident ID #2.Findings are as follows:Review of a facility policy titled Foot Care-Nail Clipping last revised 10/2022, states in part, Residents will be provided with foot care and treatment in accordance with professional standards of practice.Residents requiring toenail clipping will be referred to facility podiatrist or resident's podiatrist of choice.Record review revealed that Resident ID #2 was admitted to the facility in May of 2018 with diagnoses including, but not limited to, hemiplegia (complete paralysis of one side of the body) and hemiparesis (weakness or partial paralysis on one side of the body) following a cerebrovascular disease (stroke) affecting the left non-dominant side and peripheral vascular disease.During a surveyor observation in the presence of Licensed Practical Nurse, Staff P, on 6/16/2026 at 12:45 PM, Resident ID #2 was observed lying in bed in their room barefoot. The toenails on both his/her feet were observed to be extremely long, thickened, and curved downward toward the nail beds.During a surveyor interview immediately following the observation, Staff P acknowledged that Resident ID #2's toenails were long, thick and curving downwards. She was unaware of the last time the resident was seen by a podiatrist but revealed that a podiatrist was in the building recently. Record review revealed that the resident's last podiatry visit was on 12/10/2025. Review of the podiatry visit revealed the resident will be seen in 10 weeks, indicating the patient was due for a visit around 2/18/2026.Record review failed to reveal evidence that the resident was evaluated after 10 weeks as indicated in the podiatry visit note. Further review revealed the resident's last podiatry visit was 26 weeks prior to the observations on 6/16/2026.During a surveyor interview on 6/17/2026 at 10:07 AM with the Director of Nursing, she was unable to provide evidence of timely, required podiatry services, resulting in the resident exhibiting long, overgrown toenails.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 record review, surveyor observations, staff and resident interviews, the facility failed to provide an environment that remained as free of accident hazards as possible and failed to implement adequate supervision and interventions to prevent avoidable harm. Specifically, the facility failed to ensure safe water temperatures in resident-accessible hand sinks throughout all four resident care floors, exposing residents to the potential for serious burn injuries. In addition, the facility failed to ensure that Resident ID #2 received timely and appropriate post-fall assessment, monitoring, and interventions in accordance with facility policy following a fall, placing the resident at risk for undetected injury and potential worsening of condition. Findings are as follows:1. According to TITLE 216 - DEPARTMENT OF HEALTH, CHAPTER 40 - PROFESSIONAL LICENSING AND FACILITY REGULATION, SUBCHAPTER 10 - FACILITIES REGULATION, PART 1 - Licensing of Nursing Facilities, .In resident areas, hot water temperatures shall not be less than one-hundred degrees Fahrenheit (100 F) nor exceed one-hundred- and eighteen-degrees Fahrenheit (118 F). Thermometers [accuracy of which can be plus or minus two degrees Fahrenheit (+/-2 F)] shall be provided in each residential area to check water temperature periodically on that unit and at each site where residents are immersed or showered .Review of an undated facility procedure titled, F-689-Water Temperatures states in part, .Each state will have its own regulation on maximum water temperature allowed, but typically will fall between 105 to 115 degrees Fahrenheit(F).for burn prevention, federal guidelines advise that you keep domestic water temperature below 120 degrees Fahrenheit, although this temp can still cause burns if exposure reaches five minutes. Many states have even stricter standards that set the maximum temperatures less than 120 degrees Fahrenheit. Although 100 degrees Fahrenheit is considered a safe water temperature for bathing.Test temperature in shower areas.Check resident rooms at the end of each wing on a rotating basis or per facility policy.common area bathrooms, public bathrooms and any other areas having sinks should be checked and recorded.During a surveyor observation on 6/17/2026 at approximately 7:42 AM, the surveyor attempted to wash their hands in the first-floor public bathroom. The water temperature was too hot for the surveyor to maintain hand contact under the running stream. A digital thermometer reading at that time registered 122.1 F.Subsequent surveyor observations on 6/17/2026 revealed a systemic, facility-wide failure to regulate water temperatures within the safe, regulatory range (100 F to 120 F). The following elevated water temperatures were obtained and documented by the surveyors at the following locations:- 7:42 AM 1st floor public bathroom [ROOM NUMBER].2 F.- 8:09 AM 4th floor Resident room [ROOM NUMBER] 121.1 F.- 8:11 AM 4th floor main bathroom sink 122.4 F.- 8:20 AM 3rd floor Resident room [ROOM NUMBER] 122.9 F.- 8:23 AM 3rd floor main bathroom sink 123.7 F.- 8:38 AM 3rd floor Resident room [ROOM NUMBER] 124 F.- 8:47 AM 2nd floor Resident room [ROOM NUMBER] 121.8 F.During a surveyor interview on 6/17/2026 at 8:09 AM with Resident ID #3 s/he revealed that the water feels boiling hot and feels like it could burn his/her hands.During a surveyor interview on 6/17/2026 at 8:12 AM with Nursing Assistant (NA), Staff A, she revealed that the water sometimes feels too hot. Additionally, she further reported that she was unsure of the maximum safe water temperature for resident bathing. During a surveyor interview on 6/17/2026 at 8:33 AM with NA, Staff B she revealed that she was unsure what temperature is safe for a resident to bathe in.During a surveyor interview on 6/17/2026 at 8:35 AM with Resident ID #4, s/he revealed the water is too hot and that s/he has to let the water cool down once it is put into a basin to wash with.During a surveyor observation on 6/17/2026 at 8:52 AM in the presence of the Maintenance Staff, Staff C, the mixing valve temperature was set to 125-126 F.Record review of the facility's water temperature logs on 6/17/2026 revealed that the last recorded date for facility water temperature monitoring was completed on 1/16/2026. The facility failed to monitor, log, or track water delivery temperatures for (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	exactly five months prior to this survey, demonstrating a breakdown in preventative maintenance.During a surveyor interview directly following the above observation of the mixing valve temperature setting and of the water temperature logs with Staff C, he acknowledged that water temperatures have not been completed since January and that the water temperature at the mixing valve was set above 120 F.During a surveyor interview on 6/17/2026 at 8:55 AM with the Administrator, she acknowledged that water temperatures should not exceed 120 F. Additionally, she was unable to provide evidence that the facility ensured a safe environment was maintained, relative to water temperatures.The facility's failure to maintain water temperatures accessible to residents exceeded both state regulatory requirements and facility policy on all four resident care floors, with temperatures ranging from 121.1 F to 124 F in resident rooms and common-use areas. Resident interviews confirmed that the water was perceived as hot and capable of causing burns. Staff interviews revealed a lack of knowledge regarding safe bathing water temperatures, and facility records demonstrated that required water temperature monitoring had not been completed for approximately five months. Further observation identified the facility's mixing valve set above the maximum safe temperature range. This exposed all residents, including those with cognitive impairment, sensory deficits, impaired mobility, and decreased ability to recognize or react to hazards, to the likelihood of serious injury. The deficient practice was facility-wide, ongoing, and had the potential to affect all residents with access to resident room and common area sinks and bathing areas. The Administrator and Maintenance Staff acknowledged the excessive temperatures and the failure to conduct required monitoring. Therefore, the facility's noncompliance placed residents at risk for serious injury, serious harm, impairment, or death and constituted Immediate Jeopardy. 2. Review of a facility policy titled, Fall Prevention and Management dated 1/2023 states in part, .In the event that a resident has fallen and/or is found on the ground, a complete head to toe assessment must be performed. Only move the resident if there is a life-threatening safety concern present.Upon arrival of the nurse, a quick head to toe scan will be performed without unnecessary movement, palpating and examining all areas for breaks in the skin and/or other abnormal findings.If no obvious injury move the resident to a comfortable position. If injury, severe pain or abnormal assessment observed, call 911 for transfer.Review of a facility reported incident received by the Rhode Island Department of Health on 5/18/2026 revealed Resident ID #2 was found on the floor in his/her room in the prone position and was bleeding from his/her face. Additionally, the report revealed that the resident was admitted to the hospital following a fall and the facility was unsure if there was a new or old subdural hematoma (bleeding between the brain and skull, often due to head trauma).Record review revealed that Resident ID #2 was readmitted to the facility in May of 2026 with diagnoses including, but not limited to, dementia and a traumatic subdural hemorrhage.Review of a facility provided statement dated 5/16/2026 authored by Licensed Practical Nurse, Staff D states in part, .I observed the resident laying in the prone position between [his/her] bed and the roommates bed.I immediately alerted the second shift nurse [Staff E], and the 2nd shift supervisor, [Staff F] that the resident was on the floor face down. Myself, [Staff F], [Staff E], [Staff G], and one other male aide, who I did not get the name of, entered the room and got the patient back in bed.I noted resident's right side of face was discolored, with bruising to the cheek and forehead. Dried blood noted to right side of face and mouth and noted on floor where resident was found.Review of a facility provided statement dated 5/16/2026 authored by NA, Staff H states in part, .When I came back she told me that some one fall on the floor. So I and [Staff G] pick [him/her] from the floor with blood or fluid coming out of [his/her] nose and mouth. We put [him/her] back to bed with the two nurses present and the supervisor present.Review of an Rhode Island Emergency Medical Services Report dated 5/16/2026 states in part, .unwitness fall at a skilled nursing facility. On arrival patient was found laying in bed.Review of the hospital documentation revealed that the resident presented to the hospital after an unwitnessed fall at his/her facility with a subdural hematoma found on a CT scan (a medical imaging test that uses a series of X-ray images taken from different angles around the body and computer processing to (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adviniacare Oakland Grove LLC	560 Cumberland Hill Road Woonsocket, RI 02895

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	create detailed cross-sectional images (slices) of bones, organs, blood vessels, and soft tissues). During a surveyor interview with Staff F on 6/17/2026 at approximately 2:40 PM she revealed that she did not recall the fall or the situation surrounding it.During a surveyor interview with the Director of Nursing Services on 6/17/2026 at approximately 2:25 PM, she acknowledged staff lifted Resident ID #2 from the floor into the bed despite finding the resident prone and bleeding from the face. The DNS revealed that the facility attempts to make the residents comfortable following a fall. She was unable to provide evidence that a life-threatening environment justified the immediate move or that the staff followed the facility policy related to falls when an abnormal assessment was observed for Resident ID #2.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on clinical record review and staff interview, the facility failed to provide specialized dialysis care in accordance with professional standards of practice and the facility's policy by failing to monitor and document the patency of a newly placed Arteriovenous (AV) fistula (a surgically created connection between an artery and a vein that allows blood to flow directly from the artery into the vein, bypassing capillaries) for 1 of 1 resident reviewed, Resident ID #6. Findings are as follows:Review of the facility's policy titled Dialysis Management, revised 10/2022, revealed: .The nurse will obtain orders for monitoring of site and interventions as appropriate. Orders to include. Access site/type.Observe shunt for thrills [vibrating or buzzing sensation felt over an AV fistula, often caused by turbulent blood flow] and bruits [sound heard over an AV fistula, typically due to turbulent blood flow] .every shift.Record review revealed that Resident ID #6 was admitted to the facility in February of 2026 with diagnoses including, but not limited to, chronic kidney disease and dependence on renal dialysis (a treatment to remove extra fluid and waste from the body when the kidneys can no longer due so).Record review revealed on 5/4/2026, Resident ID #6 underwent surgical placement of a new right-arm AV fistula intended for future dialysis access.Record review failed to reveal evidence that the facility checked and documented the patency of the AV fistula every shift. Record review of Resident ID #6's clinical record from 5/4/2026 through 6/16/2026, a period of 44 days, failed to reveal evidence of documented monitoring of the newly created right AV fistula access site. Based on the facility's requirement to assess the fistula for the presence of a bruit and thrill once per shift, there were 132 monitoring opportunities during this review period. Of those 132 opportunities, documentation was absent for 124 assessments, indicating that the required monitoring was either not performed or not documented. During a surveyor interview with the Director of Nursing Services on 6/17/2026 at 1:53 PM, she revealed that she would expect the nurses to monitor the Resident's AV fistula site every shift in accordance with the facility's policy.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on clinical record review and staff interview, the facility failed to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident relative to urinary catheter (a flexible tube inserted into the bladder to empty urine) use, gastrostomy (g tube; a surgically created opening through the abdominal wall into the stomach to allow for nutrition or medications) tube care, thickened liquids, and dialysis (a treatment to remove extra fluid and waste when kidneys can no longer do so adequately) for 5 of 5 licensed staff reviewed, Staff E, M, P, Q, and R.Findings are as follows:Review of the Facility Assessment dated 6/9/2026 states in part, A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment.Services Provided Based on Resident Need.The intent is to identify and reflect on resources needed to provide these types of care.list the types of care that your resident population requires and that you provide for your resident population.intermittent or indwelling or other catheter.dialysis.end of life care.tube feeding.dietary requirements.specialized diets.1. Record review revealed that Resident ID #5 was admitted to the facility in November of 2024 with diagnoses including, but not limited to, dementia and anxiety.Review of a progress note dated 6/13/2026 authored by Registered Nurse (RN), Staff M states in part, C/o [complained of] lower abdominal cramp/discomfort. Upon assessment and palpation supra-pubic distention noted. Writer emptied 800cc [cubic centimeters. 1 cc is equal to 1 milliliter of fluid] of amber colored Urine from the bladder, Resident verbalized relief.Record review failed to reveal evidence of a physician's order for Resident ID #5 to be catheterized for urinary retention.During a surveyor interview on 6/17/2026 at 7:31 AM with RN, Staff M she acknowledged that she utilized a foley catheter to catheterize Resident ID #5 on 6/13/2026 although there was not an order to do so.Record review failed to reveal competency-based training for catheterization for Staff E, M, P, Q, and R. 2. Record review revealed that Resident ID #6 was admitted to the facility in February of 2026 with diagnoses including, but not limited to, chronic kidney disease and dependence on renal dialysis (a treatment to remove extra fluid and waste when kidneys can no longer adequately do so).Record review revealed on 5/4/2026, Resident ID #6 underwent surgical placement of a new right-arm AV fistula (a surgically created connection between an artery and a vein that allows blood to flow directly from the artery into the vein, bypassing capillaries) intended for future dialysis access.Record review failed to reveal evidence of a physician's order to assess and document the patency of the AV fistula every shift.Record review of Resident ID #6's clinical record from 5/4/2026 through 6/16/2026, a period of 44 days, failed to reveal evidence of documented monitoring of the newly created right AV fistula access site. Based on the facility's requirement to assess the fistula for the presence of a bruit and thrill once per shift, there were 132 monitoring opportunities during this review period. Of those 132 opportunities, documentation was absent for 124 assessments, indicating that the required monitoring was either not performed or not documented. Record review failed to reveal competency-based training for dialysis including, but not limited to, care of an AV fistula for Staff E, M, P, Q, and R.3. Record review revealed that Resident ID #7 was admitted to the facility in April of 2024 with a diagnosis including, but not limited to, dysphagia (difficulty swallowing).Record review revealed a physician's order dated 3/10/2026 specifying a therapeutic diet consisting of Nectar Thick Liquids (mildly thickened beverages designed to help individuals with swallowing difficulties).During a surveyor observation on 6/16/2026 at approximately 12:31 PM, Resident ID #7's meal tray was on the table in front of the resident. The meal tray contained a 4-ounce pre-packaged container of raspberry sherbet. Additionally, the sherbet was melted inside its container on the (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tray.During a surveyor observation on 6/16/2026 at 12:34 PM in the presence of Licensed Practical Nurse, Staff S, she utilized a spoon to test the consistency of the melted sherbet, observing it to have a fluid, free-flowing consistency identical to water (a thin liquid), failing to meet the required nectar consistency.Record review failed to reveal competency-based training for nectar thick liquids for Staff E, M, P, Q, and R.4. Record review revealed that Resident ID #2 was admitted to the facility in May of 2018 with diagnoses including, but not limited to, hemiplegia (complete paralysis of one side of the body) and hemiparesis (weakness or partial paralysis on one side of the body) due to cerebrovascular Disease (a stroke) affecting the left non-dominant side and gastrostomy status. Review of a physician's order dated 5/19/2026 revealed in part to elevate resident 30 -45 at all times during feeding and for one hour after gravity feeds .During a surveyor observation in the presence of Licensed Practical Nurse, Staff P, on 6/16/2026 at 12:45 PM, Resident ID #2 was observed lying in bed with the head of the bed less than 30 degrees elevated. The resident was in a fetal position. Staff P attempted to raise the head of the bed but was initially unsuccessful. Staff P then plugged the bed into the wall and was able to control the head of the bed height.During a surveyor interview immediately following the above-mentioned observation, Staff P acknowledged that the resident's head of the bed was not at the ordered height and should have been.Record review failed to reveal competency-based training for G-tubes for Staff E, M, P, Q, and R.During a surveyor interview on 6/17/2026 at 2:22 PM with the Director of Nursing Services she was unable to provide evidence that 5 licensed nurses received competency-based training on catheterization, dialysis, G-tubes, and thickened liquids although the facility assessment indicates all services are provided.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on clinical record review and staff interview, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 3 residents reviewed relative to end of life care, Resident ID #1. Findings are as follows:Review of a facility policy titled, Electronic Medication Dispenser (EMD) dated 1/2023 states in part, Policy: To have a selection of oral medications available in the facility for immediate use.The pharmacy should deliver replacement medication used for the nurse to return to the EMD.Review of a community reported complaint received by the Rhode Island Department of Health on 6/15/2026 revealed that Resident ID #1 was on hospice services and has not received his/her scheduled Morphine for more than 18 hours due to it not being available.Record review revealed that Resident ID #1 was admitted to the facility in June of 2026 with diagnoses including, but not limited to, pneumonia and respiratory failure.Record review revealed that Resident ID #1 was admitted to Hospice Services on 6/10/2026 with a diagnosis of protein calorie malnutrition.Record review revealed a physician's order for Morphine Sulfate (a narcotic) Concentrate 20 milligrams per milliliter (mg/ml), give 5 mg (0.25ml) by mouth every 6 hours scheduled for pain/shortness of breath and give 5 mg by mouth every two hours as needed for breakthrough pain or shortness of breath.Review of the June 2026 Medication Administration Record (MAR) revealed that the scheduled or as needed Morphine Sulfate was not administered on 6/11/2026.Review of a progress note dated 6/11/2026 states in part, .medication not available at this time, ordered, pharmacy called, awaiting delivery from the pharmacy.Review of the EMD supply log identified Morphine Sulfate Concentrate as an available medication.Review of the EMD Morphine Sulfate Concentrate inventory revealed it was out of stock on 6/11/2026.Review of the June 2026 MAR revealed that the scheduled or as needed Morphine Sulfate was not administered on 6/12/2026.Review of the EMD inventory revealed the Morphine Sulfate Concentrate was restocked in the inventory for use on 6/12/2026 at 2:31 PM. The Morphine Sulfate Concentrate was not available in the facility for administration on 6/11 or 6/12/2026 causing the resident to miss 7 consecutive doses.During a surveyor interview on 6/17/2026 at approximately 2:25 PM, the Director of Nursing Services (DNS) acknowledged that a review of the EMD supply logs identified Morphine Sulfate Concentrate as an available medication within the facility's inventory system but that the medication was unavailable on 6/11 and 6/12/2026. Additionally, she was unavailable to provide evidence that the facility provided pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of Resident ID #1.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on surveyor observation, staff interview, and clinical record review, the facility failed to ensure food and fluids were provided in a modified form designed to meet the individual clinical needs for 1 of 1 resident reviewed for therapeutic diets, Resident #7. Findings are as follows:According to the OnTray, LLC. Long Term Care Diet Manual, 2025 Edition, provided by the facility, .Popsicles, Ice Cream, Sherbert, Freeze Pops, Frozen Lemonade, slushies, milk shakes, or any product that melts at body temperature .cannot be thickened.Record review revealed that Resident ID #7 was admitted to the facility in April of 2024 with a diagnosis including, but not limited to, dysphagia (difficulty swallowing).Record review revealed a physician's order dated 3/10/2026 specifying a therapeutic diet consisting of Nectar Thick Liquids (Liquids that are thicker than water, fall slowly from a spoon).During a surveyor observation on 6/16/2026 at approximately 12:31 PM, Resident ID #7's meal tray was on the table in front of the resident. The meal tray contained a 4-ounce pre-packaged container of raspberry sherbet. Additionally, the sherbet was melted inside its container on the tray.During a surveyor observation on 6/16/2026 at 12:34 PM in the presence of Licensed Practical Nurse, Staff S, she utilized a spoon to test the consistency of the melted sherbet, observing it to have a fluid, free-flowing consistency identical to water (a thin liquid), failing to meet the required nectar consistency.During a surveyor interview immediately following the observation with Staff S, she acknowledged that the sherbert was not at nectar thickened consistency and was too thin for the resident.During surveyor interviews on 6/16/2026 at 12:59 PM and 1:02 PM with the Food Service Director (FSD), he acknowledged that any food item that becomes liquid at room or body temperature such as sherbet is classified as a thin liquid and must not be served to residents on a nectar-thickened diet. The FSD acknowledged that the kitchen staff should not have provided Resident ID #7 with a sherbert on his/her lunch tray.

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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. Based on surveyor observation and staff interview, the facility failed to provide and maintain a sanitary, safe, and comfortable environment by allowing the accumulation of extensive black and brown buildup throughout 3 of 3 communal shower rooms observed. Findings are as follows:A surveyor tour of the second, third, and fourth floor communal shower rooms revealed unsanitary conditions in all shower rooms observed.During a surveyor observation on 6/17/2026 at 8:11 AM, with Nursing Assistant, Staff A, the fourth-floor communal shower stall was observed to have a substantial accumulation of black and brown buildup along the lower one-fourth of the shower stall wall. Staff A acknowledged the presence of the buildup.During a surveyor observation conducted on 6/17/2026 at 8:25 AM, the third-floor communal shower stall was observed to have a similar accumulation of black and brown irregular buildup extending along the lower one-fourth of the shower stall wall.During a surveyor observation conducted on 6/17/2026 at 8:45 AM, with the Maintenance Staff, Staff C, the second-floor communal shower stall was observed to have extensive black and brown buildup covering the lower one-fourth of the shower stall wall.During a surveyor interview conducted on 6/17/2026 at 8:45 AM, Staff C acknowledged the accumulation of black and brown matter present in the shower stalls and stated that the shower stalls required cleaning.During a surveyor interview conducted on 6/17/2026 at 2:22 PM, the Director of Nursing Services stated she would expect resident shower stalls to be maintained in a clean and sanitary condition and free from accumulations of black and brown buildup. The presence of visible accumulations of black and brown buildup in 3 of 3 communal shower rooms observed demonstrates the facility's failure to maintain resident bathing areas in a clean and sanitary condition, resulting in residents being exposed to unsanitary environmental conditions.