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	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adviniacare Oakland Grove LLC	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 - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and staff interview, it has been determined that the facility failed to ensure that all residents receive treatment and care in accordance with professional standards, relative to follow up physician appointments for 2 of 2 residents reviewed, Resident ID #s 11 and 85. Findings are as follows:1. Record review revealed that Resident ID #11 was readmitted to the facility in May of 2025 with diagnoses including, but not limited to, type II diabetes and hypertension (high blood pressure).Record review revealed Resident ID #11 was transferred to the hospital on 5/4/2025 due to abdominal pain and vomiting.Review of a Discharge Summary dated 5/7/2025, revealed a referral to outpatient cardiology for chest pain.Review of a progress note dated 5/8/2025, authored by Nurse Practitioner, Staff F, revealed, the resident was seen in the hospital for chest pain and shortness of breath and is to follow up outpatient cardiology.Record review failed to reveal evidence that Resident ID #11 had a follow up appointment with outpatient cardiology.During a surveyor interview on 10/1/2025 at 10:37 AM, with Licensed Practical Nurse (LPN), Staff E, he was unaware that Resident ID #11 was supposed to follow up with outpatient cardiology following his/her hospitalization in May.During a surveyor interview with Unit Secretary, Staff G, she revealed that she schedules appointments for the unit that Resident ID #11 is on. Additionally, she revealed that she was unaware that Resident ID #11 was supposed to have a follow up appointment with cardiology. Further, Staff G looked through the appointment calendar and was unable to find an appointment for Resident ID #11 for cardiology and revealed that she will make an appointment.During a surveyor interview on 10/1/2025 at 1:41 PM, with the Director of Nursing Services (DNS), she was unable to provide evidence that Resident ID #11 followed up with outpatient cardiology, as ordered.2. Record review revealed that Resident ID #85 was admitted to the facility in July of 2025 with diagnoses including, but not limited to, necrotizing fasciitis (a bacterial infection that affects the tissue under your skin called fascia) and a right foot wound.Record review revealed Resident ID #85 had a follow up appointment with infectious disease scheduled for 9/29/2025.Record review failed to reveal evidence that Resident ID #85 went to the infectious disease appointment on 9/29/2025.During a surveyor interview on 10/1/2025 at 10:32 AM with LPN, Staff H, she acknowledged that Resident ID #85 did not go to the follow up appointment with infectious disease.During a surveyor interview on 10/1/2025 at 11:07 AM with Unit Secretary, Staff I, she revealed that she is responsible for scheduling appointments on the unit that Resident ID #85 resides on. Additionally, Staff I revealed she was unaware that Resident ID #85 had a follow up appointment with infectious disease on 9/29/2025 and that s/he did not go.During a surveyor interview via telephone on 10/1/2025 at 11:24 AM with the Unit Secretary of the Infectious Disease Provider revealed, the resident did not show up to his/her appointment on 9/29/2025. Additionally, she revealed that the facility called to make an appointment for Resident ID #85 after the missed appointment was brought to their attention by the surveyor.During a surveyor interview on 10/1/2025 at 12:53 PM with the DNS, she was unable to provide evidence that Resident ID #85 followed up with infectious disease as ordered.

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it has been determined that the facility failed to ensure that residents are free of any significant medication errors for 1 of 2 residents reviewed for antibiotics, Resident ID #85, 1 of 2 residents reviewed for pain management, Resident ID #82, and 1 of 1 resident reviewed for divalproex sodium (Depakote, a medication prescribed for off-label use to manage agitation and other challenging behaviors in dementia patients), Resident ID #30.Findings are as follows:A. Record review revealed Resident ID #82 was readmitted to the facility in April of 2025 with diagnoses including, but not limited to, low back pain and polyneuropathy (a disorder that affects nerves throughout the body potentially causing pain).Review of a Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status Score (BIMS) of 12 out of 15, indicating moderately impaired cognition. Additionally, it revealed that s/he has pain almost constantly.Review of a care plan focus area dated 4/21/2025, revealed that Resident ID #82 has pain and/or the potential for pain related to chronic left hip and back pain, and polyneuropathy. Additionally, interventions include to administer pain medications, as ordered. During a surveyor interview on 9/29/2025 at 10:32 AM with Resident ID #82, s/he expressed concerns regarding his/her pain management regarding the chronic pain.Record review revealed a physician's order for a buprenorphine patch 10 microgram/hour, and to apply one patch to the skin once daily every seven days for pain (indicating that after seven days, a new patch is applied, and the pre-existing patch is removed and discarded). Review of the September 2025 Medication Administration Record (MAR) revealed that Resident ID #82 was not administered his/her buprenorphine patch on 9/3. Further, it revealed that the next buprenorphine patch was not applied until 9/10, seven days later. Additionally, the MAR indicated to refer to the nursing progress notes for the 9/3 entry.Review of a progress note dated 9/3/2025 at 10:53 AM revealed that the buprenorphine patch was not available to be administered. During a surveyor interview on 10/2/2025 at 11:21 AM with the Director of Nursing Services (DNS), she revealed that she would expect that the buprenorphine patch would be available to be administered to Resident ID #82.B. Record review revealed Resident ID #85 was admitted to the facility in July of 2025 with a diagnosis including, but not limited to, type II diabetes.Review of a care plan focus area dated 9/26/2025, revealed that Resident ID #85 is being treated with vancomycin (an antibiotic) to treat Clostridium Difficile (C.diff).Record review revealed a physician's order for vancomycin 50 milligrams/milliliter (mL) to administer 2.5 mL, four times daily, for 10 days.Review of the September 2025 MAR revealed that Resident ID #85 was not administered his/her vancomycin on the following dates and times:-9/23: 5:00 PM and 9:00 PM-9/25: 9:00 AMDuring a surveyor interview on 10/1/2025 at 12:53 PM with the DNS, she revealed that she would expect that Resident ID #85 would have been administered his/her vancomycin, as ordered.C. Record review revealed Resident ID #30 was admitted to the facility in August of 2025 with diagnoses including, but not limited to, Alzheimer's disease and dementia.Review of a care plan focus area dated 8/11/2025, revealed that Resident ID #30 has a history of agitation and physical aggression towards staff with an intervention to provide medication as ordered.Record review revealed a physician's order for divalproex sodium 125 milligrams (mg) to give three capsules, every 12 hours.Review of the October 2025 MAR revealed that Resident ID #30 was not administered his/her Depakote for the scheduled 8:00 AM dose on 10/1 or 10/2. Additionally, the MAR indicated to refer to the nursing progress notes.Review of the progress notes revealed the following:10/1/2025 at 9:11 AM: Depakote was reordered10/2/2025 at 7:12 AM: The facility is awaiting delivery of the Depakote from the pharmacyDuring a surveyor interview on 10/2/2025 at 1:41 PM with Licensed Practical Nurse, Staff D, she revealed that the facility has a Pyxis machine (an onsite medication dispensing machine that stocks commonly prescribed medications) and she would check it if the Depakote was unavailable to be administered. Additionally, she revealed that she was unaware that the resident did not receive his/her Depakote, as ordered, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and would expect to be made aware if the resident did not receive his/her medication.Review of document provided by the facility revealed that the Pyxis machine stocks eight capsules of Depakote 125 mg.During a surveyor interview on 10/2/2025 at 2:00 PM with the DNS, she revealed that she would expect that Resident ID #30 would have received his/her Depakote, as ordered. Additionally, she revealed that she would expect staff to check the Pyxis machine for the medication first, then notify the provider if a resident does not receive his/her medication as ordered.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, record review, staff, resident, and resident representative interview, it has been determined that the facility failed to ensure each resident is treated with respect and dignity relative to 2 of 3 residents reviewed who required staff assistance for incontinence, Resident ID #s 2 and 90.Findings are as follows:1. Record review revealed Resident ID #2 was re-admitted to the facility in March of 2025 with diagnoses including, but not limited to, hemiplegia and hemiparesis (weakness on one side of the body) affecting right dominant side and benign prostatic hyperplasia (noncancerous enlargement of the prostate gland) with lower urinary tract symptoms.Record review of an annual Minimum Data Set (MDS) assessment dated [DATE] revealed, the resident has a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating s/he is cognitively intact. Additionally, s/he is always incontinent of bowel and is dependent on staff for toileting.During a surveyor interview with Resident ID #2 on 9/30/2025 at 11:44 AM, s/he revealed that s/he had soiled him/herself and needed assistance with care. The resident indicated that a staff member came in earlier around 11:00 AM and said that she would help him/her, but no one had come back or answered his/her call light.During continuous surveyor observations of Resident ID #2's room on 9/30/2025, the following was revealed: - 11:45 AM, the resident's call light was noted to be on. - 11:48 AM, Activity Aide, Staff A, brought the resident's lunch tray to his/her room. At that time, Resident ID #2 told her that s/he needed to have his/her brief changed. Staff A told Resident ID #2 to tell the nurse and the resident responded that s/he already told the staff, but no one had come in to help him/her. Staff A then left the room. - At approximately 12:00 PM, Resident ID #2 yelled Miss! I need to be changed to a staff member who walked by and did not address the resident's call light. During a subsequent surveyor interview with Resident ID #2 at this time, s/he revealed that an hour ago, s/he was allegedly told by Nursing Assistant, Staff B, that she would come back and assist him/her. Additionally, s/he stated that I sat here, ate my food while sitting on crap. - 12:20 PM, a staff member came in to drop off the resident's laundry and did not ask him/her if s/he needed anything. - 12:23 PM, Staff B came in to pick up the resident's lunch dishes. The resident told Staff B that s/he needed to be changed who replied, Just give me a minute and walked out with the resident's lunch dishes.During a surveyor observation on 9/30/2025 at 12:29 PM of the resident's incontinence care with Staff B, Resident ID #2 was observed to have had a large bowel movement.During a surveyor interview on 9/30/2025 at 12:44 PM, with Staff B, she indicated that the resident asked her to be changed at 11:45 AM but then she went on break. After informing Staff B that the surveyor had been observing the resident's room continuously for 45 minutes, she changed her story and denied that the resident had asked her to be changed prior to lunch. She acknowledged that waiting 45 minutes to be changed was unacceptable and that his/her call light should have been answered faster to assist him/her with changing his/her brief.During a surveyor interview with the Director of Nursing Services (DNS) in the presence of the Assistant Director of Nursing Services on 9/30/2025 at 2:05 PM, she indicated that the call light should be answered when it's on within reason, approximately 5 to 10 minutes, by any staff who is available to do so. Additionally, she would expect the resident to have been changed before being served his/her meal.2. Record review revealed Resident ID #90 was admitted to the facility in May of 2025 with a diagnosis including, but not limited to, dementia with behavioral disturbance.Record review of a quarterly MDS assessment dated [DATE], revealed the resident has a BIMS score of 2 out of 15, indicating severe cognitive impairment. Additional review revealed s/he requires substantial/maximal assistance of staff for toileting and personal hygiene.During a surveyor interview with the resident's family member on 10/2/2025 at 11:39 AM, s/he indicated that when s/he arrived a few minutes ago, s/he was upset that the resident was still in bed and morning care had not been completed. During a surveyor observation immediately following (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the above interview in the presence of the resident's family member, the resident was seen lying in bed with a brown stain on his/her shirt, dried brown liquid on the side of his/her mouth and was still in his/her pajamas. Additionally, the resident's hair was unkempt, and the room was noted to have a strong urine odor. During the same observation, the resident's lunch tray was delivered. The resident's family member helped him/her out of bed. When s/he stood, there was a large wet stain covering the backside of the resident's pants, and a large yellow stain on his/her bed.During a surveyor interview with NA, Staff C, on 10/2/2025 at 11:42 AM, she revealed that the resident is on her assignment for the day and she did not perform the resident's morning care including incontinence care. Additionally, she was unaware that the resident was incontinent of urine and needed to be changed.During a surveyor interview with Licensed Practical Nurse, Staff D, in the presence of the DNS on 10/2/2025 at 11:45 AM, she acknowledged that the resident had stains on his/her clothing and face and was incontinent of urine. She further acknowledged that morning care was not done and should have been completed.During a surveyor interview with the DNS on 10/2/2025 at 12:03 PM, she revealed that she would expect that residents are toileted prior to being served a meal. Additionally, she was unable to provide evidence that each resident is treated with respect and dignity.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and staff interview, it has been determined that the facility failed to implement a comprehensive person-centered care plan for each resident relative to urinary catheters for 1 of 3 residents reviewed, Resident ID #16. Findings are as follows:Review of a Clinical Competency dated 11/2017 states in part, Emptying a Urinary Drainage Bag.carefully measure urine in measuring cylinder.Record review revealed that Resident ID #16 was admitted to the facility in August of 2016 with diagnoses including, but not limited to, multiple sclerosis and neurogenic dysfunction of the bladder.Record review of a care plan revealed a focus area dated 9/18/2024 indicating, s/he has a suprapubic catheter with an intervention to monitor output for odor, color, consistency, amount, blood and sediment.Review of the Bladder Continence Task, question 3: catheter output for the last 30 days revealed 10 out of 30 days with no output documented.During a surveyor interview on 10/1/2025 at 8:10 AM with Nursing Assistant (NA), Staff C, she revealed that if a resident has a catheter the output is measured every shift and documented in the kiosk.During a surveyor interview on 10/1/2025 at 8:16 AM with Licensed Practical Nurse, Staff E, he revealed that if a resident has a catheter the Nursing Assistants measure the output every shift and report it to the nurse. Additionally, Staff E acknowledged the missing days of output documentation for Resident ID #16.During a surveyor interview on 10/1/2025 at 8:21 AM with the Director of Nursing Services, she acknowledged the missing days of output documentation for Resident ID #16. Additionally, she was unable to provide evidence that the facility followed the comprehensive care plan for Resident ID #16.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing for 1 of 2 residents observed for wound care, Resident ID #14. Findings are as follows: Review of a facility policy titled, Clean Dressing Technique, states in part, .Procedure: Check physician order for current, correct treatment.Sanitize hands and apply clean gloves. Remove old dressing and discard.Remove gloves, sanitize hands and apply clean gloves.Record review revealed the resident was admitted to the facility in September of 2025 with diagnoses including, but not limited to, type I diabetes and pressure wounds to his/her left heel, right foot, right hip, and sacrum (the lower back/base of the spine).Review of a care plan focus area dated 9/4/2025 revealed, the resident has multiple pressure wounds and that s/he is seen by the wound physician weekly. Additionally, it indicates to treat the wounds, as ordered.Record review revealed the following wounds and respective treatment orders:-Wound #1: Right hip - Cleanse with wound cleanser, apply collagen with silver (a wound treatment), and cover with a foam dressing daily and as needed.-Wound #2: Coccyx - Cleanse with wound cleanser, apply collagen with silver (a wound treatment), and cover with a foam dressing daily and as needed.-Wound #3: Right lateral foot - Skin prep (a skin protectant), and cover with a foam dressing every other day and as needed.-Wound #4: Right heel - Cleanse with wound cleanser, apply xeroform (a wound treatment) cut to size of wound bed, and cover with a bordered dressing twice daily and as needed.-Wound #5: Left heel - Skin prep twice daily.During a surveyor observation on 9/30/2025 at approximately 12:00 PM, with Licensed Practical Nurse, Staff J, she began dressing wound #1 and applied collagen powder to the wound, instead of collagen with silver as ordered, then applied the foam dressing. Staff J proceeded to wound #2 and again, applied collagen powder to the wound, instead of collagen with silver as ordered, then applied the foam dressing. Staff J then completed dressing changes for wounds #3 and #4. Staff J then proceeded to wound #5 and was noted to cleanse the wound, then removed her gloves and applied new gloves without first performing hand hygiene. Staff J then applied a clean dry dressing to the wound, which was observed to be open and had drainage. During surveyor interviews on 9/30/2025 at 12:50 PM and 1:11 PM, with Staff J, she acknowledged that she did not utilize collagen with silver for wounds #1 and #2. Additionally, she acknowledged that she did not perform hand hygiene in between removing the gloves used to cleanse wound #5 and before donning clean gloves to apply a clean dressing.During a surveyor interview on 10/1/2025 at 12:26 PM with the Wound Physician, she revealed that she would expect staff to have used collagen with silver because that is what was ordered.During a surveyor interview on 10/1/2025 at 12:49 PM with the Director of Nursing Services, she revealed that she would expect staff to have followed the wound treatment orders and perform hand hygiene between glove changes.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on surveyor observation and staff interview, it has been determined that the facility failed to store and label drugs and biologicals in accordance with currently accepted professional principles for 1 of 3 floors observed, the 3rd floor. Findings are as follows:1. During the medication storage and labeling task on 9/29/2025 at approximately 9:25 AM, in the presence of Certified Medication Technician (CMT), Staff K, observation of the 3rd Floor Northwest CMT medication cart revealed, 3 medication cups labeled with residents' room numbers containing multiple medications in each cup.During a surveyor interview at the time of the above observation with Staff K, he indicated that he pre-poured the resident's medications and that the residents were unavailable at the time they were prepared.During a surveyor interview on 9/28/2025 at 1:28 PM with the Director of Nursing Services (DNS), she indicated that pre-pouring medications is against the facility's policy and would expect the medications to be disposed of if the residents were unavailable. 2a. Review of a facility policy titled Medication Storage states in part, .Medication must be stored in accordance with manufacturer's specifications.all medications shall expire on the date specified by the manufacturer on the product label, unless the manufacturer has specifically indicated a shortened expiration once opened on the product label itself.During the medication storage and labeling task on 9/29/2025 at 8:56 AM, in the presence of Licensed Practical Nurse (LPN), Staff L, observation of the 3rd Floor Northwest Nurse medication cart revealed a bottle of Narcan with a manufacturer's expiration date of 6/2025. During a surveyor interview at the time of the above observation with Staff L, she acknowledged the expired Narcan and indicated that it should have been removed from the cart. 2b. During the medication storage and labeling task on 9/29/2025 at 8:49 AM, in the presence of LPN Staff L, observation of the 3rd floor medication fridge revealed, an open undated vial of a Tuberculin Purified Protein Derivative (an injectable test to aid in the diagnosis of tuberculosis,), 5 tuberculin units per 0.1 milliliters, opened and stored in the medication refrigerator. Additional observation failed to reveal evidence of a date when opened or an expiration date. Review of the Manufacturer's instructions for the Tuberculin Purified Protein Derivative solution revealed to discard the open medication after 30 days. During a surveyor interview at the time of the above observation with Staff L, she acknowledged the open undated bottle of Tuberculin Purified Protein Derivative, and acknowledged the medication was open and undated. Additionally, she was unable to identify when the medication expired. During a surveyor interview on 9/28/2025 at 1:28 PM with the DNS, she indicated that she would expect medications to be store and labeled properly in the medication cart and fridge, in accordance with the manufacturer's instructions.