STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415009	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kent Regency Center	660 Commonwealth Avenue Warwick, RI 02886

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42399 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that residents receive adequate supervision to prevent accidents, relative to supervision while toileting for 1 of 4 residents reviewed, Resident ID #1. Findings are as follows: According to the State Operation Manual Appendix PP- Guidance to Surveyors for Long Term Care Facilities, last revised 2/3/2023, states in part, .Supervision is an intervention and a means of mitigating accident risk. Facilities are obligated to provide adequate supervision to prevent accidents. Adequacy of supervision is defined by type and frequency, based on the individual resident's assessed needs, and identified hazards . Record review of a facility reported incident reported to the Rhode Island Department of Health on 3/8/2024 states that Resident ID #1 was transferred to the bathroom with the assistance of two staff members. One of the staff then stepped out of the room for a moment to get a wheelchair and supplies. When the staff member returned to the resident, s/he was found on the floor. This report states in part, .No injury was noted after initial assessment by Nursing . Additionally, the report revealed that the resident's family requested for the resident to be transferred to the hospital for evaluation and s/he was admitted with a diagnosis of intracerebral hemorrhage (brain bleed) on 3/7/2024. Record review revealed that the resident was admitted to the facility from the hospital in March of 2024 with diagnoses including, but not limited to, cerebral infarction (stroke), left sided weakness, and diabetes. Record review of hospital documentation titled Discharge Summary, dated 3/6/2024, states in part, Diagnoses .Ischemic stroke .Cerebral edema .Cognition- .pt [patient] has sig [significant] impaired attention with max 30 seconds. Pt highly distracted .[S/he] started on low dose Ritalin to assist with stroke-related cog [cognition] impairment/inattention .OT [Occupational Therapy] Discharge Summary: two assist for toileting hygiene for safety .limiting function: Balance deficits, Cognition, endurance, pain, positioning, Postural control, Upper Extremity Function . (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the resident's care plan dated 3/6/2024 states in part, Resident requires assistance/is dependent for ADL [Activities of Daily Living] .toileting related to: s/p [status post] CVA [cerebrovascular accident], Additional review of the care plan revealed an intervention stating in part, .stand on weaker side of resident/patient when assisting with ADLs or other activities . Record review of an admission nursing progress note dated 3/6/2024 states in part, .Pt is lethargic with flat affect. Able to follow simple instructions. Spanish speaking only .Pt has L-arm [left] sling due to L-sided weakness with facial droop. Incontinent of bowel and bladder . Resident is a two person assist for all transfers and uses a wheelchair for assistive device. Additional record review revealed a progress note authored by the Nurse Practitioner (NP) on 3/7/2024 which indicates that the resident sustained a fall off the toilet earlier that morning at approximately 8:30 AM. The note revealed s/he was transferred to the toilet by staff and was then left in the bathroom alone for approximately two minutes while a Nursing Assistant (NA) went to go get a wheelchair. When the staff returned, the resident was found on the floor. The resident was assisted back to bed by staff and was examined by the Nurse Practitioner with recommendations to send him/her to the hospital emergency room per the family's request. During her examination, the resident denied dizziness, pain, or hitting his/her head. Record review of a RI EMS [Emergency Medical Services] Patient Care Report dated 3/7/2024 states in part, .Pt is alert and oriented, Spanish speaking only, family on scene is able to interpret .CC [complaints] of left sided head pain, left scapula area pain, left sided neck pain, following a fall from a seated position on the toilet .Pt has mild tenderness to the left scapula area . Record review of a progress note dated 3/7/2024 at 5:40 PM states, Resident was admitted to [hospital name redacted] at 1700 [5:00 PM] for Fall/ICH [Intracerebral hemorrhage]. Record review of a hospital document titled, ED [Emergency Department] Provider Note dated 3/7/2024, states in part, History of present illness .[S/he] fell off toilet today in [his/her] rehab center .[s/he] struck the left side of [his/her] head and left shoulder .[S/he] only complains of head and chronic left shoulder pain . Record review of an additional hospital document titled, ED to Hospital admitted d 3/7/2024, states in part, [S/he] presents after minor trauma. Neuroimaging identifying subacute and acute hemorrhagic transformation within [his/her] right MCA [middle cerebral artery] chronic infarct [a small, localized area of dead tissue resulting from failure of blood supply] . During a surveyor interview on 3/12/2024 at 1:52 PM with NA, Staff A, she revealed that she and NA, Staff B transferred the resident to his/her wheelchair and then onto the toilet. She further revealed the resident is Spanish speaking and she was translating for the resident and Staff B. Additionally, she revealed that after the resident was transferred to the toilet, she left the room to assist other residents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 3/12/2024 at 2:04 PM with NA, Staff B, she revealed that on 3/7/2024 at approximately 8:15 AM, she assisted the resident with Staff A to his/her wheelchair and then transferred the resident from his/her wheelchair onto the toilet. While she was in the bathroom with Resident ID #1, a staff member from the Therapy Department came into the room and needed to take the wheelchair. She further revealed that she then left the resident alone in the bathroom to go and find another wheelchair. Additionally, she revealed that when she returned to the bathroom after approximately two minutes, she found the resident on the floor. During a surveyor interview with the Director of Nursing Services on 3/12/2023 at approximately 9:44 AM, she acknowledged that Resident ID #1 was left alone in the bathroom prior to his/her fall. She was unable to provide evidence that the resident received adequate supervision to prevent an accident. 50004