

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024
NAME OF PROVIDER OR SUPPLIER Lincolnwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 610 Smithfield Road North Providence, RI 02904	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46539</p> <p>Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that the residents environment remains free of accident hazards relative to falls for 1 of 3 residents reviewed, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Review of a community reported complaint submitted to the Rhode Island Department of Health on 10/14/2024 revealed that the resident had a witnessed fall in his/her room and was transferred to the hospital via 911 with head lacerations.</p> <p>Record review revealed that the resident was readmitted to the facility in October of 2024 with a diagnosis including, but is not limited to, dementia.</p> <p>Review of the Fall Risk Evaluation, dated 10/8/2024, revealed the resident is at high risk for falls.</p> <p>Review of a Functional Abilities & Goals (Admission) assessment dated [DATE] revealed that the resident is dependent on staff for rolling to the left and right. It further revealed an intervention which included, but is not limited to, the resident is dependent on two staff while utilizing a sheet for turning and repositioning.</p> <p>Review of the resident's care plan revealed a problem start date of 10/10/2024 that the resident has an Activity of Daily Living self-care performance deficit related to dementia. Further review revealed an intervention which includes, but is not limited to, the resident is dependent on two staff and a sheet for turning and repositioning.</p> <p>Review of the resident's Kardex (a tool used by the direct care staff to provide pertinent information to guide resident care) from 10/10/2024 revealed that the resident is dependent on two staff while utilizing a sheet for turning and repositioning.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a progress note dated 10/14/2024 at 11:39 AM, revealed the nurse was called to the resident's room by a Certified Nursing Assistant (NA). Upon entering the resident's room, the resident was noted to be lying on the floor on his/her back. The resident was observed to be bleeding from his/her head. Further assessment revealed that the resident was noted with a laceration to his/her forehead and was bleeding from the back of his/her head. The note further revealed that the NA turned the resident onto his/her side and then turned away from the resident to pick up some wipes. The resident rolled over and hit his/her face on the bed side chair and then fell on to the floor landing on his/her back. The resident was transported to the hospital via 911.</p> <p>Record review revealed a nursing note dated 10/15/2024 indicated that the resident returned from the emergency room at 12:15 AM. S/he had dissolvable sutures to the laceration above the right eye and a dressing covering the laceration to the back of the head.</p> <p>During a surveyor interview with NA, Staff A on 10/17/2024 at approximately 9:12 AM she indicated that she was in the room alone providing care to the resident. She indicated that when she rolled the resident over to provide incontinence care, the resident jerked a little and fell down face first. The resident's face then hit the arm of the bed side chair where the resident then did a 360 and ultimately landed on his/her back. Staff A revealed that the facility uses an online Kardex and care plan to identify what care and assistance each resident requires. She further indicated that she was unaware that the resident required two staff members to assist with bed mobility and turning in bed.</p> <p>During a surveyor interview with Licensed Practical Nurse, Staff B, on 10/17/2024 at 10:11 AM, she revealed that the facility utilizes a Kardex to communicate the residents needs to the staff. Staff B reviewed the Kardex with the surveyor and acknowledged that the resident requires two staff members to assist with bed mobility and turning in bed and acknowledged that there was only one staff member present at the time of the fall.</p> <p>During a surveyor interview with the Director of Nursing Services on 10/17/2024 at approximately 11:49 AM, she revealed that the resident should have been a one assist with care, although she acknowledged that the facility assessed the resident as a two assist with care. She further stated that the formal assessment tool titled Functional Abilities & Goals (Admission) which triggered the resident require a two assist with bed mobility and turning, was in error. She further acknowledged that the Kardex and the care plan that two staff members are required to provide care and assistance with bed mobility and turning to the resident at the time s/he fell out of bed and sustained a laceration to his/her forehead and the back of his/her head was also in error.</p> <p>It is to be noted that this injury to the resident resulted in one staff member assisting with care and not the two staff as required based upon the results of the assessment tool.</p>		