STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415042	A. Building B. Wing	07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Villa Rehabilitation and Health Care Cen	1275 South Broadway East Providence, RI 02914

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and resident interview, it has been determined that the facility failed to ensure that each resident receives adequate care to prevent an accident for 1 of 1 resident reviewed. The resident required two staff members to assist during care, one staff member was providing care, resulting in the resident falling out of bed, injuring multiple areas, including a facial injury requiring immediate transfer to the hospital and hospitalization, Resident ID #1. Findings are as follows:Record review of a facility reported incident submitted to the Rhode Island Department of Health on 7/18/2025 revealed Resident ID #1 rolled out of bed after morning care, and s/he was sent to Rhode Island Hospital via 911 for evaluation. Record review revealed the resident was originally admitted to the facility in November of 2023 with diagnoses including, but not limited to, anoxic brain damage (brain does not receive enough oxygen), seizures, and diabetes.Record review of the Minimum Data Set (MDS) assessment dated [DATE], revealed that the resident is dependent on staff for bed mobility and that two staff members are required to assist during this task.Record review of the MDS assessment dated [DATE] revealed the resident is dependent on staff during a shower or bath. Additionally, the MDS revealed that two staff members are required to assist during this task.Record review of the resident's care card (a documentation system that enables staff to reference key resident information that shapes their nursing care plan) revealed the resident is dependent for the following care areas: - Personal Hygiene with assist of 2 staff members - Shower or Bathe self with assist of 2 staff members - Roll left or right with assist of 2 staff members Record review of a nursing progress note dated 7/16/2025 revealed the resident fell out of bed, with some bleeding noted from the head and face. Additionally, the resident was sent out to the hospital for evaluation.Record review of the hospital documentation dated 7/16/2025 revealed the resident was evaluated for a 0.5-centimeter (cm) laceration near the right eyebrow, and an abrasion to the left elbow and right knee. During a surveyor interview on 7/21/2025 at 10:30 AM with Nursing Assistant, Staff A, she indicated that on 7/16/2025, she was providing care by herself and completed a full bed bath on the resident and then untucked the bed sheet in an attempt to change him/her. Staff A revealed she tried to pull the sheet off of the bed and the resident fell off the bed onto his/her bottom and then she witnessed the resident hit his/her head on the floor. Additionally, Staff A revealed that she normally works alone while providing care for the resident. She stated that she could not recall the information documented on the care card or MDS regarding the number of staff required to provide care for this resident. During a surveyor interview on 7/21/2025 at 1:55 PM with Licensed Practical Nurse (LPN), Staff B, he indicated that on 7/16/2025, Staff A requested help after the resident fell onto the floor. He entered room and described the resident as alert, and s/he had some blood on his/her face. Staff B called the rescue for the resident to be transported to Rhode Island Hospital for an evaluation. During a surveyor interview conducted on 7/21/2025 at approximately 2:30 PM with the Director of Nursing Services (DNS), she stated that staff may request assistance with care if they feel it is necessary. The DNS noted that the resident typically holds onto the bed rail to assist with turning during care. However, the DNS did not acknowledge that two staff members are required when providing hygiene or bed bath care, despite documentation in the MDS and care card indicating this requirement.Record review revealed that at the time of this survey, the resident remained in the hospital. Due to the facility's failure to follow the MDS Assessment and care card directives, Staff A provided care alone without the required assistance of a second staff member. As a result, Resident ID #1 fell from the bed to the floor, sustaining multiple injuries, including trauma to the face.