STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415054	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Kingstown Nurs. & Rehab Ctr	2115 South County Trail West Kingston, RI 02892

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, and staff and resident interviews, the facility failed to ensure residents remained free from abuse and neglect for 1 of 1 resident reviewed when staff refused the resident's repeated requests for toileting assistance. Specifically, the facility failed to provide necessary care and services to a continent resident, resulting in the resident being left heavily saturated in urine and forced into an incontinent episode. This failure caused actual harm, including the development of a urinary tract infection (UTI) and psychosocial harm, for Resident ID #124.Findings are as follows:Review of a facility reported incident submitted to the Rhode Island Department of Health on 4/23/2026 revealed that Resident ID #124 alleged that Nursing Assistant (NA), Staff A, refused to assist him/her to the bathroom, instead instructed him/her to void in his/her brief, and did not change him/her when requested, during third shift on 4/22/2026 into 4/23/2026. According to ElderAbuse.org, elder neglect includes, but is not limited to, the failure to provide basic assistance to [an] older person who cannot self-perform daily living tasks like bathing, feeding, dressing, or going to the bathroom. Elder neglect can cause harm such as .Hygiene-Related Health Problems.like urinary tract infections.Record review revealed Resident ID #124 was admitted to the facility on [DATE] with diagnoses including, but not limited to, spinal stenosis (the narrowing of spaces within the spine) and surgical aftercare following surgery. Further review revealed the resident was discharged home on 5/3/2026. Review of the hospital Continuity of Care Form dated 4/22/2026 revealed the following provider discharge instructions following spinal surgery:- .full weight bearing.- .Do not remove your dressing. We will remove it at your 2 week follow up appointment.call the office if the dressing becomes saturated- .You are encouraged to be up and walking.Further review of the hospital documents revealed the resident required contact guard with ambulation with his/her rolling walker and assistance with transfers.Record review of the admission progress note dated 4/23/2026 at 12:52 AM, revealed the resident was admitted to the facility on [DATE] at 4:30 PM via ambulance and was transferred into bed by ambulance staff. Further review revealed the resident is alert and oriented to person, place, and time, had a surgical dressing to his/her lower back that was clean, dry and intact, and was continent of bowel and bladder. Additional review revealed the resident could ambulate with a rolling walker and staff assistance.Record review of a care plan dated 4/22/2026 revealed safe patient handling is one person assist with gait belt and rolling walker.Record review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status score of 14 out of 15, indicating intact cognition. Further review revealed the resident is always continent of urine.Record review revealed the following nursing progress notes:-4/23/2026- the resident was able to make his/her needs known, required assist with activities of daily living (ADLS), and ambulates with assistance and a rolling walker. Further review revealed the resident was administered Valium (a medication prescribed to treat anxiety) twice for complaints of increased anxiety. Additional review revealed the surgical dressing to the resident's lower back was changed due to urine saturation and a message was left for the orthopedic surgeon.-4/24/2026 at 6:35 AM- the resident complained of urinary frequency and burning (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 0600 Level of Harm - Actual harm Residents Affected - Few	with urination. -4/24/2026 at 7:44 PM- the resident reports urinary frequency and burning with urination. Symptoms reported to the physician and a new order was given to obtain a urinalysis with a culture and sensitivity (UA C&S- a urine test used to diagnose urinary tract infections).-4/25/2026- the resident complains of urinary frequency and burning with urination, urine sample obtained as ordered and ready for lab pick up.-4/26/2026- the resident complains of urinary frequency and burning with urination. UA results reported to the provider. New order given for Bactrim DS (an antibiotic) twice daily for three days.-4/28/2026 at 12:34 PM - the resident's surgical dressing to his/her back was saturated with serosanguinous drainage (thin pink drainage) this morning. Dressing removed with visible redness and maceration (the softening or breakdown of skin caused by the prolonged exposure to moisture) to the incision and a copious amount of drainage observed.-4/28/2026 at 10:03 PM- call out to the orthopedic surgeon to report the redness to the surgical incision and moderate serosanguineous drainage. An appointment was scheduled for 4/29/2026.-4/29/2026 at 1:41 PM- resident out to orthopedic surgeon this morning for evaluation of surgical incision. A new order was received for a daily dressing change.During surveyor interviews on 5/8/2026 at 12:31 PM and on 5/11/2026 at 9:25 AM with Nurse Manager, Staff B, she indicated that she worked first shift on 4/23/2026 and found the resident anxious and upset that s/he was incontinent of urine on that morning since s/he was continent most of the time. She revealed that the resident reported to her that the Nursing Assistant on third shift refused to assist him/her to the bathroom which resulted in him/her being incontinent of urine. She further revealed that the surgical incision dressing was saturated with urine and required a dressing change which should not have been changed until the scheduled orthopedic follow up appointment in May. Additionally, she revealed that the resident began having urinary symptoms, was found to be positive for a UTI, and was treated with antibiotics soon after the incident. Furthermore, she revealed that nursing should review the hospital paperwork for functional status so they can communicate with the NA's who are providing care to the resident. During a surveyor interview on 5/11/2026 at 9:10 AM with the alleged perpetrator, NA, Staff A, she revealed that during third shift on 4/22/2026 into 4/23/2026 she refused to assist Resident ID #124 to the bathroom and further revealed that resident requested to be assisted into the bathroom multiple times. She indicated that she told the resident that she could not assist him/her to the bathroom because s/he had not been assessed by physical therapy yet. Additionally, she revealed she did not assist the resident with incontinence care prior to leaving the facility. During a surveyor interview on 5/11/2026 at 9:32 AM with the Director of Rehab, she revealed that she would expect nursing staff to review a resident's hospital discharge documents for the resident's transfer and ambulation status and implement those instructions until the facility's therapy staff can evaluate the newly admitted resident. During surveyor interviews on 5/8/2026 at 12:51 PM and on 5/11/2026 at 9:44 AM with the Director of Nursing Services, she revealed that Resident ID #124 was able to transfer and ambulate to the bathroom with assistance on admission. She further revealed that the resident reported that NA, Staff A refused to assist him/her to the bathroom during third shift on 4/22/2026 into 4/23/2026, did not offer him/her a bed pan, and told him/her to urinate in his/her brief. Additionally, she revealed that the resident required a dressing change to the surgical incision as it was found to be saturated in urine and that Staff A was terminated from the facility following the incident. Furthermore, she revealed that she would expect nursing staff to review the resident's hospital paperwork for transfer and ambulation status and that staff would assist the resident as needed.During a surveyor telephone interview on 5/12/2026 at 10:35 AM with Resident ID #124, s/he revealed that s/he requested to be assisted to the bathroom many times on third shift, but the staff refused to assist him/her. The resident revealed that s/he was incontinent of urine and became very upset because the staff refused to assist him/her. S/he further revealed that his/her surgical incision dressing became itchy and saturated with urine following the incontinence episode caused by the staff's refusal to assist him/her to the bathroom. Additionally, Resident ID #124 revealed that s/he was not assisted to the bathroom when necessary multiple times that night and later had to be treated for a UTI.The facility's (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	failure to keep the resident free from neglect resulted in psychosocial and physical harm to the resident as evidenced by the resident's increased anxiety following the incident, experiencing urinary symptoms and being diagnosed with a UTI, and requiring dressing changes and an unscheduled outpatient visit with the orthopedic surgeon to evaluate the status of the resident's surgical incision, 8 days prior to the scheduled follow up visit.