STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415078	A. Building B. Wing	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Respiratory and Rehabilitation Center of RI	10 Woodland Drive Coventry, RI 02816

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**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 provide effective cardiopulmonary resuscitation (CPR) consistent with basic life support protocols to a resident who was found without a pulse or respirations, Resident ID #3. 1. Record review revealed Resident ID #3 was admitted to the facility in August of 2025 with diagnoses including, but not limited to, acute and chronic respiratory failure with hypoxia (low levels of oxygen in the blood) and a tracheostomy (a surgical procedure to create an opening through the neck into the windpipe to facilitate breathing).Record review revealed that Resident ID #3 was a full code indicating that s/he wishes to receive life saving measures including CPR, which consists of chest compressions and rescue breaths, if required, in the event of a medical emergency.Review of a progress note dated [DATE] at 7:10 AM, authored by Respiratory Therapist (RT), Staff D, revealed that at approximately 5:45 AM, Resident ID #3 was found unresponsive on the toilet by another staff member who called for help. Additionally, Staff D, rushed into the room and immediately started providing rescue breaths via the Ambu bag (resuscitation bag) as Registered Nurse (RN), Staff E, was performing chest compressions. Further, an Automated External Defibrillator (AED, a portable device used to treat a person whose heart has suddenly stopped working) was applied.Additional review of the progress notes revealed a note dated [DATE] at 7:49 AM, authored by Licensed Practical Nurse (LPN), Staff G, revealed that Resident ID #3 was pulseless and not breathing. A code was called, and CPR was initiated by Staff D, Staff E, and himself (Staff G). Further, rescue personnel arrived approximately 10 minutes after they were called and had resumed CPR efforts.Review of the emergency personnel report (EPR) dated [DATE] revealed that they were dispatched to the facility at approximately 6:10 AM and arrived on scene to find Resident ID #3 in his/her bed, unresponsive and cyanotic [a blue/purple discoloration of the skin and mucous membranes due to insufficient oxygenation of the blood]. Rescue personnel noted the facility staff performing CPR on Resident ID #3 but were only conducting chest compressions. The documentation failed to indicate that Resident ID #3 had been receiving supplemental oxygen and rescue breaths via an Ambu bag prior to their arrival. Additionally, the EPR revealed rescue personnel began providing Resident ID #3 with 15 liters (L) of oxygen and rescue breaths at 12 breaths per minute (bpm) via an Ambu bag, and s/he was subsequently transferred to the hospital.Review of the hospital documentation dated [DATE] revealed that Resident ID #3 arrived at the Emergency Department at 7:12 AM and was pronounced dead at 7:21 AM. The documentation indicates that rescue personnel informed the hospital staff that the facility staff were performing CPR to the resident while s/he was in bed.1a. According to an article titled, The optimal surface for delivery of CPR: An updated systematic review and meta-analysis of the National Library of Medicine dated July of 2024 states in part, .(CPR) is considered a crucial first step in managing a cardiac arrest as chest compressions play a vital role in maintaining hemoperfusion [blood flow] to the brain, heart and other vital organs. The International Liaison Committee on Resuscitation (ILCOR) and its member organizations emphasize high-quality chest compressions as part of the cardiac arrest chain of survival with current guidelines recommending chest compression depth of 5-6 cm [centimeters] in children and adults.Performing adequate chest compressions on soft surfaces, such as a mattress, poses challenges as it can compress both the chest and surface itself. up to 57 [percent] of the compression force may be absorbed by the mattress resulting in insufficient compression depth and increased provider fatigue.The need for additional force to counteract the mattress's absorption may further exacerbate provider fatigue. The insertion of backboards.or the movement of patients to the floor have been proposed to counter the impact of soft surfaces.During a surveyor interview on [DATE] at 10:18 AM with LPN, Staff G, he revealed when Resident ID #3 was found unresponsive on the toilet, he and other staff members transferred the resident from the toilet to his/her bed and began performing chest compressions. Additionally, he further revealed that they did not use a backboard at any point when they were performing CPR. During a surveyor interview on [DATE] at 2:20 PM with the Director of Nursing Services (DNS), in the presence of the Administrator, he revealed that he would have expected that staff would have moved Resident ID #3 from the toilet to the floor to perform CPR instead of transferring him/her to a bed. Additionally, he revealed that if CPR efforts were performed while the resident was in bed, he would have expected a backboard to have been used.1b. Review of a facility policy titled, PROCEDURE: OXYGEN: RESUSCITATION BAG (AMBU BAG) last revised [DATE] states in part, .For a patient who has a tracheostomy attach the resuscitation bag directly to the tracheostomy tube Ventilate by squeezing the bag

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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 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 services provided by the facility meet professional standards of quality relative to following physician's orders for 1 of 3 residents reviewed for a physician referral for an appointment, Resident ID #5.Findings are as follows:According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, The physician is responsible for directing medical treatment, Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients.Record review revealed that the resident was admitted to the facility in August of 2022 with diagnoses including, but not limited to, hemiplegia and hemiparesis following cerebral infarction (weakness and paralysis of one side of the body following a stroke), dependence on ventilator, use of tracheostomy (a surgically created opening in the windpipe to assist with breathing) and gastrostomy (a surgical opening into the stomach for purposes of feeding).Review of a progress noted dated 8/3/2025 revealed that the resident sustained a witnessed fall while a Nursing Assistant (NA) was changing his/her brief and landed on his/her bilateral knees. Additionally, the note revealed that the resident complained of 10 out of 10 pain and was to have x-rays of the affected area. Review of a, Radiology Results Report dated 8/4/2025 states in part, .Findings.there is a fracture of the distal tibia and fibula.Review of a progress note dated 8/4/2025 states in part, Resident returned from hospital with report of: [Resident ID #5] has a left ankle fracture. We placed in a splint. [S/he] will need to follow up with outpatient orthopedics/podiatry in 1 week.Review of a progress note dated 8/12/2025 authored by Physician Assistant (PA), Staff M, states in part, .Nursing staff understands that patient should have orthopedic follow-up.Review of a progress note dated 9/4/2025 authored by Staff M, states in part, Nursing staff instructed to reach out to orthopedic and offer virtual visits with me in attendance to help them. They are established at then send x-ray results to orthopedic.Review of a progress note dated 9/22/2025 authored by Physician, Staff N, states in part, .outpatient orthopedic follow-up.Record review failed to reveal evidence that Resident ID #5 had an Orthopedic follow up as ordered.During a surveyor interview on 10/27/2025 at 2:33 PM with transport aide, Staff O, she revealed that she made an appointment for Resident ID #5 with an orthopedic clinic however, the office cancelled the appointment. Additionally, Staff O revealed that she spoke with PA, Staff M, about the cancelled appointment and believed that he was going to be scheduling an appointment for Resident ID #5.During a surveyor interview on 10/28/2025 at 9:11 AM with Staff M, in the presence of the Administrator he revealed that he does not schedule resident appointments and did not schedule an orthopedic appointment for Resident ID #5. Additionally, he revealed he would expect the staff at the facility to follow orders including making appointments.

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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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 the resident environment remains as free of accident hazards relative to falls for 1 of 3 residents reviewed, Resident ID #5. The facility failed to implement the resident's care plan, leading directly to an accident and injury to resident #5, who sustained a left distal tibia (large shinbone) and fibula (smaller shinbone) fracture.Findings are as follows:Review of a community reported complaint received by the Rhode Island Department of Health on 10/24/2025 alleges that Resident ID #5 sustained 2 falls and did not get the appropriate care related to his/her injuries.Record review revealed that the resident was admitted to the facility in August of 2022 with diagnoses including, but not limited to, hemiplegia and hemiparesis following cerebral infarction (weakness and paralysis of one side of the body following a stroke), dependence on ventilator, use of tracheostomy (a surgically created opening in the windpipe to assist with breathing) and gastrostomy (a surgical opening into the stomach for purposes of feeding).Review of a care plan last updated on 7/29/2025 revealed an intervention that states, [Resident ID #5] requires assist of 2 for bathing, dressing, grooming, incontinent care.Review of an Annual Minimum Data Set assessment dated [DATE] revealed that the resident is totally dependent on staff for all activities of daily living including, turning from side to side, toileting, and transfers.Review of a progress noted dated 8/3/2025 revealed that the resident sustained a witnessed fall while a Nursing Assistant (NA) was changing his/her brief and landed on his/her bilateral knees. Additionally, the note revealed that the resident complained of 10 out of 10 pain and was to have x-rays of the affected area.Review of a, Radiology Results Report dated 8/4/2025 states in part, .Findings. there is a fracture of the distal tibia and fibulal fracture.Review of a facility provided statement authored by NA, Staff L, revealed that she was providing incontinence care to Resident ID #5 alone when s/he rolled out of bed and onto the floor.An interview was attempted with Staff L with no return call. During a surveyor interview on 10/28/2025 at approximately 12:00 PM with the Director of Nursing Services in the presence of the Administrator he was unable to provide evidence that the staff followed the care plan relative to utilizing 2 staff members for incontinence care.As the facility failed to follow the care plan with regards to utilizing two staff members for incontinence care, this resident was rolled off of the side of the bed and sustained a left distal tibia and fibula fracture. This failure by the facility to ensure that staff consistently implemented resident-specific interventions outlined in the care plan, thereby not providing care in accordance with accepted standards and the resident's assessed needs.

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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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **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 the resident's physician completed a medication reconciliation upon readmission. This failure resulted resulted in a resident receiving the medication Metolazone (a medication prescribed to treat fluid retention) in error, Resident ID #1. Findings are as follows:Record review of a facility reported incident submitted to the Rhode Island Department of Health on [DATE] revealed that Resident ID #1 had experienced a fall on [DATE] and was transferred to an acute care hospital. Additionally, the resident subsequently died.Record review revealed Resident ID #1 was readmitted to the facility in October of 2025 with a diagnosis including, but not limited to, heart failure, pulmonary hypertension (a condition where the blood pressure in the arteries of the lung is high), and chronic kidney disease.Review of the progress notes revealed the resident was transferred to an acute care hospital and was admitted for congestive heart failure, exacerbation, and respiratory distress on [DATE] and was later readmitted to the facility on [DATE].Review of a hospital document titled, Continuity of care adult discharge dated [DATE], revealed that the resident was readmitted with an order for Metolazone 5 milligrams (mg) by mouth, three times a week.Review of a physician's order dated [DATE], entered by Registered Nurse, Staff A, revealed the order for Metolazone 5 mg was incorrectly transcribed into the record to be given three times daily instead of three times a week.Review of a progress note authored by the Resident ID #1's physician dated [DATE] revealed that he saw the resident that day at approximately 5:00 PM following his/her readmission to the facility. Additionally, he indicated that s/he was started on Metolazone 5 mg, three times a week.Record review failed to reveal evidence that Resident ID #1's physician identified the Metolazone order transcription error upon seeing the resident and reviewing his/her medical record.During a surveyor interview on [DATE] at 11:03 AM with the resident's physician, he revealed that he had seen the resident at approximately 5:00 PM on [DATE], the day after his/her readmission. Additionally, he indicated that he reviewed the resident's medical record but failed to identify the Metolazone transcription error. He further revealed that he does not reconcile the medication orders in the facility's system with the hospital continuity of care form because it is not feasible. Further, he revealed that it is the nursing staff's responsibility and that is why they have a medication verification checklist in place.During a surveyor interview [DATE] at approximately 10:32 AM with the Director of Nursing Services, he revealed that it is his expectation that the provider would reconcile the resident's medical record with the hospital continuity of care documents to ensure accuracy.Cross reference F 726 and F 760

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	**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 have sufficient nursing staff to assure resident safety and attain the highest practicable, physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care relative to insufficient staffing for 1 of 3 residents reviewed for a fall, Resident ID #5. Findings are as follows:Review of a community reported complaint submitted to the Rhode Island Department of Health on 10/24/2025 alleged that Resident ID #5 who is a .quadriplegic [paralysis of both arms and legs], dependent on a ventilator and feeding tube, and fully reliant on staff for all aspects of [his/her] care. the complaint alleged that on 9/29/2025, Resident ID #1 was found on the floor with a broken nose. Furthermore, the complaint alleged that the facility is .severely understaffed.Record review revealed that the resident was admitted to the facility in August of 2022 with diagnoses including, but not limited to, hemiplegia and hemiparesis following cerebral infarction (weakness and paralysis of one side of the body following a stroke), dependence on ventilator, use of tracheostomy (a surgically created opening in the windpipe to assist with breathing) and gastrostomy (a surgical opening into the stomach for purposes of feeding).Record review revealed that the resident sustained a fall on 9/29/2025 at 8:15 PM when the resident fell out of bed and was found on the floor which resulted in a nasal fracture.Review of the facility provided investigation file revealed that the facility was unaware of how the resident fell out of bed.Review of the statements authored by Nursing Assistant (NA), Staff P, dated 9/29/2025 revealed that on 9/29/2025, around 6:00 PM the NA and nurse went to assist a resident that required total dependence with care and required the 3 NA's working on the unit, a nurse from the unit and an additional NA from another floor to transfer the resident to bed safely. Additional review of the statement revealed that she asked the Administrator for help, but that he had to leave to pick up his kids. Further review of the statement revealed that with only three NAs on the floor, they .answered lights and did the best that they could. Around 7 PM this NA observed staff rushing into Resident ID #5's room, yelling that the resident is on the floor.During a surveyor interview with NA, Staff Q, on 10/28/2025 at 11:09 AM, she revealed that upon the beginning of her shift on 9/29/2025, they had 2 NA's until 4 PM and then another NA came. She revealed that the unit requires more staff than 2 NAs for the whole floor. She indicated that she reported to the management team that they needed more assistance on the unit but that none came. Furthermore, she revealed that while her and 4 other staff members were in another resident's room for a long time transferring the other resident, no other staff were present on the unit to be available if the other residents required assistance.During a surveyor interview with NA, Staff R, on 10/28/2025 at 11:26 AM, she revealed that on 9/29/2025 the unit was unsafe at the time of the event. She revealed that there was only 3 NAs working. Additionally, she revealed that if there was more staff that the resident probably wouldn't have fallen.Review of the facility assessment dated [DATE]-2026, revealed that staffing assignments are based on patient volume/density and acuity. Further review of the facility assessment failed to identify the average number of staff required to ensure sufficient number of qualified staff are available to meet each resident's needs, in the assessment or attached to the assessment in the supporting document section.Review of a document titled Staffing Guidelines that was provided after the surveyor notified the Administrator that their facility assessment does not identify the average number of staff required to ensure a sufficient number of qualified staff are available to meet each resident's needs, revealed that on the 3:00 PM to 11:00 PM shift, the unit that Resident ID #5 resides on, requires 5/4 NA's.Review of the facility's actual working schedule for the 3:00 PM to 11:00 PM shift on 9/29/2025 revealed, only two nurses and three NAs worked on the unit, and not the 5/4 NA's as stated in the Staffing Guidelines.During a surveyor interview on 10/28/2025 at approximately 1:55 PM, with the Administrator and Director of Nursing Services, they indicated that they were aware there were only 3 NAs scheduled to work on the unit. Additionally, they could not provide evidence that they followed their staffing guidelines and/or adjusted the staffing assignments based on patient volume/density and acuity of the unit. Furthermore, they acknowledged that Residents ID #5 had an unwitnessed fall from bed on 9/29/2025 where s/he fractured his/her nasal bone and at the time of the fall the unit was staffed with 3 NA's instead of the 5/4 NA's, as stated in the staffing guidelines.The facility failed to ensure that sufficient staffing levels were maintained in accordance with the facility's own staffing guidelines and resident acuity needs. As a result, Resident ID #5, who is fully dependent on staff for care, experienced an unwitnessed fall resulting in a nasal fracture. This demonstrates a failure by the facility to provide

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**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 have sufficient nursing staff with the appropriate skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident relative to the medication verification process for the readmission of Resident ID #1 that involved six staff members, Staff A, B, C, E, the Assistant Director of Nursing Services (ADNS), and the resident's physician, that resulted in a significant medication error for Resident # 1. Additionally, the facility failed to have nursing staff with the appropriate skills set regarding the care and treatment of Resident ID #1 after s/he was found unresponsive on the floor. Further, the facility failed to have nursing staff with the appropriate skills set to provide effective cardiopulmonary resuscitation (CPR) consistent with basic life support protocols for a resident who was found without a pulse or respirations, Resident ID #3Findings are as follows:Review of the Facility assessment dated [DATE]-2026 revealed that the facility requires mandatory education and training/competencies based on job title including accident prevention/staff and resident safety as well as ventilator (a machine that assists with breathing) and tracheostomy (a surgical procedure to create an opening through the neck into the windpipe to facilitate breathing) management. Additionally, required services include respiratory, physician, and skilled nursing services, as well as medication management.1. Record review revealed Resident ID #3 was admitted to the facility in August of 2025 with diagnoses including, but not limited to, acute and chronic respiratory failure with hypoxia (low levels of oxygen in the blood), and a tracheostomy.Record review revealed that Resident ID #3 was a full code indicating that s/he wishes to receive life saving measures including CPR, which consists of chest compressions and rescue breaths, if required, in the event of a medical emergency.Review of a progress note dated [DATE] at 7:49 AM, authored by Licensed Practical Nurse (LPN), Staff G, revealed that Resident ID #3 was pulseless and not breathing. A code was called, CPR was initiated by Respiratory Therapist (RT), Staff D, Registered Nurse (RN), Staff E, and himself (Staff G). Further, rescue personnel arrived approximately 10 minutes after they were called and had resumed CPR efforts.Review of the emergency personnel report dated [DATE] revealed that they arrived on scene to find the facility staff performing CPR on Resident ID #3 while s/he was in bed. Emergency personnel noted that facility staff were only performing chest compressions. Further, rescue personnel began providing Resident ID #3 with 15 liters (L) of oxygen and rescue breaths at 12 breaths per minute (bpm) via an Ambu bag (resuscitation bag), and s/he was subsequently transferred to the hospital.Record review revealed that the resident later died at the hospital.According to an article titled, The optimal surface for delivery of CPR: An updated systematic review and meta-analysis of the National Library of Medicine dated July of 2024 states in part, .(CPR) is considered a crucial first step in managing a cardiac arrest as chest compressions play a vital role in maintaining hemoperfusion [blood flow] to the brain, heart and other vital organs. The International Liaison Committee on Resuscitation (ILCOR) and its member organizations emphasize high-quality chest compressions as part of the cardiac arrest chain of survival with current guidelines recommending chest compression depth of 5-6 cm [centimeters] in children and adults. Performing adequate chest compressions on soft surfaces, such as a mattress, poses challenges as it can compress both the chest and surface itself.up to 57 [percent] of the compression force may be absorbed by the mattress resulting in insufficient compression depth and increased provider fatigue.The need for additional force to counteract the mattress's absorption may further exacerbate provider fatigue. The insertion of backboards.or the movement of patients to the floor have been proposed to counter the impact of soft surfaces.Additionally, review of a facility policy titled, PROCEDURE: OXYGEN: RESUSCITATION BAG (AMBU BAG), last revised [DATE] states in part, .For a patient who has a tracheostomy.attach the resuscitation bag directly to the tracheostomy tube.Ventilate by squeezing the bag with sufficient force to cause the chest to rise.Squeeze the bag once every five to six seconds [equivalent to 10-12 bpm].During a surveyor interview on [DATE] at 10:18 AM with LPN, Staff G, he revealed that Resident ID #3 was found unresponsive on the toilet by another staff member who called for help. He further revealed that he and other staff members transferred the resident from the toilet to his/her bed and began performing CPR. Additionally, he indicated that a backboard was not used at any point during CPR. During a surveyor interview on [DATE] at 3:23 PM with RT, Staff D, he revealed that he was the only staff member that used the Ambu bag during CPR until rescue personnel arrived on scene and resumed CPR efforts. He further revealed that he set the

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**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 1 resident reviewed who received Metolazone (a diuretic medication prescribed to treat fluid retention by increasing urine production) not as intended, Resident ID #1. Findings are as follows:Record review of a facility reported incident submitted to the Rhode Island Department of Health on [DATE] revealed that Resident ID #1 had experienced a fall on [DATE] and was transferred to an acute care hospital. The resident subsequently died.Record review revealed Resident ID #1 was readmitted to the facility in October of 2025 with a diagnosis including, but not limited to, heart failure, pulmonary hypertension (a condition where the blood pressure in the arteries of the lung is high), and chronic kidney disease.Review of a care plan dated [DATE] revealed a focus area that s/he is at risk for dehydration related to medications including diuretics with interventions that include to administer medications as ordered. Review of the progress notes revealed the resident was transferred to an acute care hospital and was admitted for congestive heart failure exacerbation and respiratory distress on [DATE] and was later readmitted to the facility on [DATE].Review of a facility policy titled, .Medication Errors. states in part, . [facility] shall ensure medications will be administered.according to prescriber's orders.Review of a hospital document titled, Continuity of care adult discharge dated [DATE], revealed that the resident returned with an order for Metolazone 5 milligrams (mg) by mouth three times a week. Additionally, the resident was to also continue on a fluid restriction, medications to lower his/her blood pressure, and another diuretic medication. Review of the prescriber information packet for Metolazone revealed the following adverse/side effects: orthostatic hypotension (a condition characterized by a sudden drop in blood pressure when standing up, leading to symptoms like fainting and dizziness), syncope (a temporary loss of consciousness due to reduced blood flow to the brain), dizziness/lightheadedness, drowsiness, fatigue, and weakness.Review of a physician's order dated [DATE], entered by Registered Nurse, Staff A, revealed the order for Metolazone 5 mg was incorrectly transcribed to be given three times daily instead of three times a week.Review of the [DATE] Medication Administration Record revealed that Resident ID #1 had received Metolazone 5 mg three times on both 10/10 and 10/11, and once on 10/12, indicating that s/he received a total of seven doses within three days instead of the two doses, as ordered.Review of the nursing progress notes revealed the following:-[DATE] at 11:00 PM: The resident's Metolazone 5 mg order was incorrectly transcribed resulting in the resident receiving his/her Metolazone 5 mg three times on 10/10 and [DATE]. Additionally, the note indicates that the resident's physical exam revealed that s/he appeared fatigued.-[DATE] at 7:42 AM: The resident's blood pressure had been obtained and was noted to be 102/58 (a normal blood pressure reading is 120/80 and a low blood pressure reading is considered anything below 90/60. Low blood pressure has the potential to cause dizziness, fainting, confusion, and/or nausea).-[DATE] revealed that on [DATE] at approximately 5:25 PM, the resident was found on the floor of his/her room unresponsive and bleeding from his/her face. His/her blood pressure was noted to be 78/29 at that time. Additionally, the resident was transferred to an acute care hospital via rescue and subsequently died.Review of the Emergency Medical Services (EMS) documentation dated [DATE] revealed when EMS arrived on scene, the resident was found face down on the floor in a large pool of blood. Further, the report noted that facility staff were attempting to apply a nasal cannula for oxygen delivery, reaching beneath the resident's head without confirming airway patency or assessing for respirations. EMS rolled the resident on his/her back and their primary assessment revealed s/he had extensive facial trauma, a large hematoma (a collection of blood outside of the blood vessels) to the forehead, swelling around both eyes, and significant bleeding of the mouth and nose that had visible clots. More importantly, the resident was found to not be breathing, and EMS inserted an artificial airway device and began providing rescue breaths via an Ambu bag (resuscitation bag).During a surveyor interview on [DATE] at 12:00 PM with Licensed Practical Nurse, Staff F, she revealed that she identified the medication error regarding the resident's Metolazone and notified a provider, prior to the resident's unwitnessed fall. She further revealed that the provider had ordered blood work, a blood pressure reading to be obtained, and an ultrasound of the heart. Additionally, she revealed that the resident appeared more sleepy.During a surveyor interview on [DATE] at approximately 2:25 PM with Respiratory Therapist, Staff J, she revealed that she entered the resident's room after she witnessed staff rushing in to find the resident face down on the floor in a pool of blood. She further revealed that the resident receives continuous oxygen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415078	A. Building B. Wing	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Respiratory and Rehabilitation Center of RI	10 Woodland Drive Coventry, RI 02816

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on record review and staff interview, it has been determined that the facility failed to conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment.Findings are as follows:Review of a community reported complaint received by the Rhode Island Department of Health on 10/24/2025 alleges that Resident ID #5 sustained 2 falls and did not get the appropriate care related to his/her injuries. Additionally, the complaint alleges that the facility does not have enough staff or qualified staff.Review of a document titled, Facility Assessment dated March 2025-2026 states in part, .Acuity-Sufficiency Analysis Summary.4. Please document total #[number]/average/range of staff required to ensure sufficient number of qualified staff are available to meet each resident's needs: Kindly reference the attached Staffing and Personnel Worksheet in the Attachments section of this Facility Assessment.Further review of the Facility Assessment revealed multiple sections for supporting documentation that state, no records were found. Additionally, there was not a Staffing and Personnel Worksheet completed in the facility assessment. Additional review of the Facility Assessment revealed a previous employee listed as the Administrator and not the current Administrator.During a surveyor interview on 10/28/2025 at 12:25 PM with the Administrator he acknowledged that the Facility Assessment is not complete and does not accurately reflect the staffing patterns of the facility or have the current Administrator listed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415078	A. Building B. Wing	10/28/2025

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and staff interview, it has been determined that the facility failed to ensure that resident's records are complete and accurately documented, relative to 1 of 1 resident reviewed who received Metolazone (medication to treat fluid retention) inaccurately, Resident ID #1. Findings are as follows:Record review of a facility reported incident submitted to the Rhode Island Department of Health on 10/14/2025 revealed that Resident ID #1 had experienced a fall and was transferred to an acute care hospital to be treated. However, the facility was later informed that the resident had passed away.Record review revealed the resident was readmitted to the facility in October of 2025 with diagnoses, including but not limited to, heart failure (a condition in which the heart muscle cannot pump blood effectively), pulmonary hypertension (a condition where the blood pressure in the arteries of the lung is high) and chronic kidney disease.Record review of a hospital document titled Continuity of Care Adult Discharge dated 10/9/2025 revealed that the resident was discharged with a list of medications which include, but is not limited to, Metolazone 5 milligrams by mouth three times a week for 30 days.Record review of a physician's order dated 10/9/2025, entered into the electronic medical record by Registered Nurse, Staff A, revealed Metolazone 5 milligrams by mouth three times a day instead of three times a week, as ordered.Record review of the October 2025 Medication Administration Record revealed the resident had received 7 doses of the above-mentioned medication in 3 days instead of 2 doses, as ordered. During a surveyor interview on 10/15/2025 at 1:15 PM with the Director of Nursing Services, he acknowledged that the resident's Metolazone 5 mg order was incorrectly transcribed resulting in the resident receiving the medication three times on 10/10 and 10/11, and once on 10/12/2025 when s/he should have received the Metolazone 5 mg three times a week.