

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>415078                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                             | (X3) DATE SURVEY<br>COMPLETED<br><br>06/17/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Coventry Operations RI LLC DbA Respiratory and Reh                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>10 Woodland Drive<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                      |                                                 |
| F 0600<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review and staff interview, the facility failed to ensure that a resident remained free from physical abuse for 1 of 3 residents reviewed, pertaining to Resident ID #2 when Resident ID #1 physically assaulted the resident by pushing him/her against a door and holding a butter knife to his/her neck. Findings are as follows: Review of a facility reported incident submitted to the Rhode Island Department of Health on 6/1/2026 revealed that Resident ID #1 pushed Resident ID #2 against a door and placed a butter knife against his/her neck. Both residents were immediately separated by staff. There were no injuries to either resident. Resident ID #1 refused to hand the butter knife to staff but did hand it to the police officer shortly thereafter. Resident ID #1 was sent to the hospital for further evaluation. Record review revealed the alleged perpetrator, Resident ID #1, was admitted to the facility in September of 2025 with diagnoses including, but not limited to, dementia with behavioral disturbances, major depressive disorder, anxiety disorder, adjustment disorder, and alcohol dependence. Record review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a score of 99 which indicates the interview was unable to be completed. Review of a care plan focus area dated 9/30/2025, revealed Resident ID #1 has impaired cognition and exhibits verbal and physical behaviors, ineffective coping skills, and poor anger management. Record review revealed that the victim, Resident ID #2, was admitted to the facility in February of 2015 with diagnoses including, but not limited to, dementia with behavioral disturbances, paranoid schizophrenia, personality disorder, major depressive disorder, and anxiety disorder. Record review of a Quarterly MDS assessment dated [DATE] revealed a Brief Interview for Mental Status score of 8 out of 15, indicating moderately impaired cognition. Review of a care plan focus area dated 3/4/2015, revealed the resident has a history of verbal outbursts directed toward others. Interventions include, but are not limited to, monitor for signs of agitation, redirect, and have the resident refocus on something positive. Record review of a progress note for Resident ID #1, dated 6/1/2026 at 3:48 PM, revealed that she/he was sent to the hospital for evaluation after an assault, pushing a resident, and threatening a resident with a butter knife. Record review of a progress note for Resident ID #2, dated 6/1/2026 at 2:00 PM, found that this nurse witnessed this resident be pushed by another resident in the hall. This nurse quickly intervened and multiple staff intervened. This nurse removed this resident from the other resident and brought him/her back to his/her room. Resident had no complaints of pain and no new skin issues noted. During a surveyor interview conducted on 6/17/2026 at approximately 1:15 PM, the Director of Nursing Services (DNS) stated that when Resident ID #2 walked past Resident ID #1, Resident ID #1 unexpectedly stood up, pursued Resident ID #2, cornered him/her against a door, and held a butter knife near his/her neck. The DNS further stated that Resident ID #1 refused staff requests to relinquish the butter knife, and law enforcement was contacted to assist with the situation. She was unable to provide evidence that Resident ID #2 was kept free from physical abuse.</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