STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415087	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenville Skilled Nursing and Rehabilitation	735 Putnam Pike Greenville, RI 02828

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46118 Based on record review, staff and resident interview it has been determined that the facility failed to treat each resident with respect and dignity in an environment that promotes maintenance of his or her quality of life for 1 of 3 residents reviewed, Resident ID #1. Findings are as follows: Review of the facility policy titled, Resident Rights Under Federal Law, states in part, .To promote and protect the rights of the resident .the right to request, refuse, and/or discontinue treatment . Record review of a facility reported incident submitted to the Rhode Island Department of Health on 4/14/2025 indicated that Resident ID #1 reported that s/he was held down by a staff member after refusing medications. The report further alleges that the nurse administered the medications via the resident's gastrostomy (G-Tube- a tube that is surgically inserted through the abdomen and placed directly into the stomach) after s/he had refused the medications multiple times. Record review revealed that the resident was admitted to the facility in April of 2024 with diagnoses including, but not limited to, Cerebral Palsy (a condition that effects muscle movement and posture caused by brain damage most often at birth) and dysarthria (a motor speech disorder). Review of the Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 15 out of 15, indicating intact cognition. Record review of the care plan dated 9/17/2024 revealed the resident has impaired communication with interventions including, but not limited to, allowing the resident sufficient time to process and respond. Record review revealed a physician's order dated 1/7/2025 indicating medications may be given by mouth if unable to access the G-Tube. Record review revealed a progress note dated 4/13/2025 indicating that the resident was combative and kicking staff while administering medications. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the April 2025 Medication Administration Record (MAR) revealed the resident was administered the following medications on 4/13/2025 at 6:00 AM: -Diltiazem 60 milligrams (mg) -Eliquis 5 mg -Folic Acid 1 mg -Furosemide 20 mg -Gabapentin 300 mg -Keppra 10 milliliters (ml) -Lactulose 10 grams -Metoprolol Tartrate 50 mg -Senna 8.6 mg -Sertraline 100 mg -150 ml water flush During a surveyor interview on 4/15/2025 at approximately 3:00 PM with the resident, s/he verbally stated that a couple of days ago, staff held his/her arms down and administered medications after s/he said no repeatedly. The resident further stated that s/he did not like that and that the staff should have known better. During a surveyor interview on 4/15/2025 at approximately 3:20 PM with the Nursing Educator, she indicated that the resident is alert and oriented and can make his/her needs known. However, the resident can be difficult to understand. She further indicated that the resident takes his/her medications by mouth and/or via G-Tube. During a surveyor interview on 4/15/2025 at 3:28 PM with Registered Nurse, Staff A, she indicated that she worked 3:00 PM to 11:00 PM on the resident's unit on 4/13/2025 and the Nursing Assistant (NA), Staff B told her that she had held the resident's hands down that morning so the nurse could administer his/her medications. Staff A further indicated that she reported this incident to a supervisor immediately. During a surveyor interview on 4/15/2025 at 3:36 PM with NA, Staff B, she indicated that the resident was kicking and screaming because s/he didn't want to take his/her medications. She further indicated that the nurse asked her to help, so she rubbed the resident's arm and distracted him/her while the nurse administered his/her medications via the G-Tube. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the written statement dated 4/15/2025 from Registered Nurse (RN) Staff C, she indicated that the resident was nonverbal and was being combative while she was attempting to administer the resident's medications. The statement further indicated that the resident did not want to take the medications by mouth so she administered them via G-tube. An attempt to interview RN, Staff C, was made on 4/15 and 4/16/2025, however, she was unable to be contacted via telephone. During a surveyor interview on 4/16/2025 at 8:40 AM with the Director of Nursing Services and the Administrator, they indicated that if a resident refuses medication, the nurse should not administer the medication and notify the provider of the refusal. Additionally, they indicated that the resident is able to make his/her needs known and is not usually combative with staff.

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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** 46118 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 with an injury of unknown origin, Resident ID #2, and for 1 of 1 resident reviewed who experienced an actual fall, Resident ID #3. Findings are as follows: 1. Review of a facility reported incident submitted to the Rhode Island Department of Health on 4/10/2025 revealed Resident ID #2 sustained an injury of unknown origin to his/her left lower leg during care and was sent to the hospital for an evaluation .large, deep half circle with moderate bleeding . The report further indicated that the resident returned to the facility with sutures to the wound. Review of a facility policy titled, Safe Resident Handling/Transfer Equipment states in part, Safe Resident Handling involves the use of assistive devices to ensure that patients can be transferred safely .A Gait Belt [a safety device that wraps around a resident's waist to assist with safe transfers] is used with patients who can .perform stand pivot transfer with limited/minimal assistance with one staff member . Record review revealed Resident ID #2 was originally admitted to the facility in July of 2024 with a diagnosis including, but not limited to, Alzheimer's Disease, dementia, difficulty in walking, and unsteadiness on feet. Record review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident is usually understood, experiences difficulty communicating some words or finishing thoughts, but is able if prompted or given time. Additionally, it reveals that s/he sometimes understands and can respond adequately to simple, direct communication only. Further review revealed the resident requires supervision or touching assistance (a helper to do less than half of the effort. Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for chair/bed-to-chair transfers and to go from sitting to standing. Record review of the resident's Kardex (a documentation system that enables nurses to write, organize, and easily reference key resident information that shapes their nursing care plan) reveals the resident requires a partial assist, substantial assist to safely transfer to and from a bed to a chair/wheelchair. Record review failed to reveal evidence of a physician's order with indications on how the resident transfers. Review of the [unit name redacted] Unit Ambulation/Transfer log, states in part, [Resident ID #2] assist of 1 for transfers w[with] walker. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of a progress note dated 4/9/2025 revealed the nurse was called to the resident's room by a Nursing Assistant (NA) when a large, deep, half circle wound was noted with moderate bleeding. The on-call provider was notified, and the resident was transferred to the hospital for sutures. Record review of the hospital documentation dated 4/9/2025 revealed the resident was evaluated for a large wound on his/her left leg. Further review revealed 13 sutures were placed to close the wound. During a surveyor interview on 4/15/2025 at 1:21 PM with NA, Staff D, she indicated that on the evening of 4/9/2025, she completed upper body care for the resident but was asked by the nurse to assist with another resident who was getting an x-ray. Staff D then revealed that she asked NA, Staff E to assist the resident with a transfer to bed because he had previously offered to help. Additionally, she revealed that when she returned to the resident's room, 10 minutes later, the resident was in bed with his/her pants and shoes still on, she noticed blood seeping through the resident's pants and onto the bed and then the new wound to the resident's left lower leg was identified. Furthermore, Staff D revealed that had the resident been bleeding prior to being transferred to bed she would have noticed it while providing him/her with upper body care. Record review of an undated written statement authored by NA, Staff E, revealed in part, that he was watching the dining room, when Staff D asked him to help transfer Resident ID #3. Staff E revealed that Staff D then went to help another resident and he was relieved from watching the dining room, so he went to Resident ID #3's room and transferred him/her to bed. The statement further reveals that the resident was combative, and he left him/her in bed with his/her clothes on so Staff D could take care of him/her. During a surveyor interview on 4/15/2025 at 1:30 PM with NA, Staff E, he indicated that on 4/9/2025 around 6:45 PM, he transferred the resident from his/her wheelchair into his/her bed by holding the resident's upper arm as the resident was holding onto the bedrail. He further indicated that he did not use a walker or a gait belt for the transfer. Additionally, he indicated that he did not notice any bleeding during the transfer and did not remove any of the resident's clothes, as s/he was not on his assignment, and he was only helping to transfer him/her into bed and then left the room. During a surveyor interview on 4/15/2025 at approximately 3:00 PM with the Director of Nursing Services, she indicated that she would expected a walker and a gait belt to have been utilized when Staff E transferred Resident ID #2 on the evening of 4/9/2025. The result of the facility's failure to utilize a walker and to implement their safe resident handling policy by applying a gait belt to the resident resulted in Resident ID #2 being transferred to the hospital for an evaluation of a new wound to his/her left lower leg and receiving 13 sutures. 2. Review of a facility reported incident submitted to the Rhode Island Department of Health on 4/14/2025 revealed Resident ID #3 had a new onset of hip pain, and the resident reported that s/he had an unwitnessed fall. The resident was admitted to the hospital with a left hip fracture. Review of a facility policy titled, Falls Management states in part, .Patients experiencing a fall will receive the appropriate care and post-fall interventions will be implemented .Implement and document patient-centered interventions according to individual risk factors in the patient's plan of care . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review revealed Resident ID #3 was admitted to the facility in February of 2025 with diagnoses including, but not limited to, dementia, muscle weakness, and a history of falls. Record review of the MDS assessment dated [DATE] revealed the resident had severe cognitive impairment. Further review revealed the resident was independent with transfers and ambulation. Record review of a progress note dated 4/7/2025 revealed a bruise was noted to the resident's left bicep measuring 4 centimeters (cm) by 3.75 cm. Record review revealed a Change in Condition [CIC] Evaluation dated 4/8/2025 was completed due to an unwitnessed fall resulting in a bruise that was noted to be purple and blue in color. Further review revealed no other injuries were noted. Record review of a care plan dated 2/15/2025 revealed the resident is at risk for falls. Further review failed to reveal evidence that an intervention had been put into place to prevent falls following the resident's unwitnessed fall on 4/7/2025. Record review of an After Hours Telehealth Consult dated 4/12/2025, revealed the resident had an unwitnessed fall, complained of left hip pain and is unable to raise the left leg. Further review revealed the resident would not allow the nurse to touch his/her leg, however, the supervisor noted the left leg to be shorter than the right with the left hip externally rotated. Additional review revealed an order was given to transfer the resident to the hospital for an evaluation. Record review revealed a CIC Evaluation was completed on 4/12/2025 for a fall resulting in left hip pain and outward rotation. Further review revealed the resident stated that s/he had fallen. Record review of the hospital documentation dated 4/15/2025 revealed the resident was admitted to the hospital following a fall and was found to have a left hip fracture and a urinary tract infection. Further review revealed surgery was completed to repair the hip. Additionally, the resident was discharged back to the facility on [DATE]. During a surveyor interview on 4/16/2025 at approximately 10:00 AM with the Nursing Educator, she indicated that she was working the floor on 4/7/2025 when the bruise was noted to the resident's bicep and that the resident had reported that s/he fell . She further indicated that an unwitnessed fall was assumed to be the cause of the bruise, and a CIC evaluation was completed. She further acknowledged that no new fall interventions were put into place following the unwitnessed fall on 4/7/2025. During a surveyor interview on 4/16/2025 at 10:50 AM with the Director of Nursing Services, she indicated that she would expect new interventions to be put into place following an unwitnessed fall. During a surveyor interview on 4/16/2025 at 11:30 AM with the Administrator, she indicated that Physical Therapy (PT) was going to evaluate the resident that day and that the care plan was updated late. She further indicated that the resident had not been evaluated by PT after the resident's unwitnessed fall on 4/7/2025 and acknowledged that no new interventions were put into place for further fall prevention. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of a revised care plan that was given to the surveyor by the Administrator upon exit, revealed the fall care plan was revised on 4/16/2025 to include a new intervention for a PT evaluation with an initiation date of 4/7/2025.