

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/05/2025
NAME OF PROVIDER OR SUPPLIER Bethany Home of Rhode Island		STREET ADDRESS, CITY, STATE, ZIP CODE 111 South Angell Street Providence, RI 02906	

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	<p>**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 each resident receives adequate supervision to prevent an accident while ambulating for 1 of 1 resident reviewed for falls who sustained significant injuries, multiple fractures of his/her vertebral bones of the spine, Resident ID #1. Findings are as follows: Review of a facility reported incident submitted to the Rhode Island Department of Health on 11/4/2025 revealed that Resident ID #1 was being walked from the toilet to the sink by a staff member and caught his/her foot on the floor and fell, striking the left side of his/her head and landing on his/her back. Additionally, it revealed that the resident sustained multiple fractures to the bones of his/her spine. Record review of the Safe Patient Handling policy indicates that approved patient handling aids shall be used to prevent manual lifting and handling of residents. Review of a hospital Discharge summary dated [DATE] revealed a moderate T4 (the fourth thoracic vertebra) compression fracture (a break in a vertebra) with a 2-millimeter (mm) retropulsion (when a piece of the vertebra bone breaks away), a severe T12 compression fracture with a 7 mm retropulsion, and a compression fracture of the 5th Lumbar vertebrae. In addition, it revealed that the findings were absent on prior imaging. Record review revealed that Resident ID #1 was admitted to the facility in March of 2023 with diagnoses including, but not limited to, generalized muscle weakness and back pain. Review of the Minimum Data Set assessment dated [DATE] revealed the resident requires assistance of 1 staff for walking 10 feet once standing and for toileting transfers. Further it indicates staff lifts, holds, or supports the trunk or limbs, but provides less than half the effort. Review of a care plan last revised on 9/23/2025, revealed that the resident can walk short distances around his/her room using a rolling walker with the assistance of 1 staff member. Record review of the Care Profile Report (a summary outlining the resident's current care status, medical conditions, and support needs) indicated that the resident requires assistance from one staff member for ambulation using a rolling walker and gait belt (a sturdy strap, usually made of canvas, nylon, or leather, that caregivers use to help safely support and assist a person when walking or transferring). Review of an Occupational Therapy document dated 11/5/2025 revealed that Resident ID #1 fell in the bathroom on 11/4/2025, was sent to the hospital, and returned to the facility with a severe decline from the fall. Additionally, it revealed that the resident is very fearful of all movement since his/her fall. Review of the resident's progress notes revealed the resident had not sustained any falls in the last 6 months. During a surveyor interview on 11/5/2025 at 11:21 AM with Resident ID #1 s/he revealed that s/he was coming out of the bathroom with his/her walker and fell. Additionally, s/he revealed that s/he began experiencing back pain as a result of the fall. During a surveyor interview on 11/5/2025 at 11:26 AM with Registered Nurse, Staff A, she revealed that the resident needs staff assistance ambulating in his/her room and requires a walker and a gait belt. During a surveyor interview on 11/5/2025 at 11:40 AM with Nursing Assistant (NA), Staff B, she revealed that she regularly assists Resident ID #1 and utilizes a gait belt when she ambulates with him/her. During surveyor interviews on 11/5/2025 at 12:00 PM and 12:44 PM with the Occupational Therapist, Staff C, she revealed that the resident has been receiving therapy in order to maintain his/her highest level of functioning and has never complained of back pain. Additionally, she revealed that the resident is now complaining of pain and had a significant decline after the fall on 11/4/2025. Furthermore, she revealed that she would expect staff to use a gait belt to ambulate the resident, as it is a standard of practice for all residents who require assistance. During a surveyor interview on 11/5/2025 at 12:22 PM with NA, Staff D, she revealed that she was the staff assisting the resident at the time of the fall and did not assist lift, hold, or support the trunk or limbs of Resident ID #1. Additionally, Staff D acknowledged that she had not applied the gait belt to the resident and was unable to assist in preventing the fall despite being near the resident. Staff D indicates that she normally utilizes a gait belt when assisting the resident. The facility's failure to ensure that staff followed the resident's care plan and implemented proper safety measures specifically, the use of a gait belt when assisting Resident ID #1 with ambulation resulted in the resident sustaining multiple spinal fractures and a significant decline, due to a preventable fall.</p>		