STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415010	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Elizabeth Home East Greenwich	1 Saint Elizabeth Way East Greenwich, RI 02818

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 - Minimal harm or potential for 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** 46539 Based on record review, and staff interview it has been determined that the facility failed to protect and keep residents free from physical abuse relative to an incident that occurred between Resident ID #1 and #2, resulting in a skin tear for Resident ID #2. Findings are as follows: Review of a facility policy titled, Abuse prohibition states in part, .It is the policy of this facility to ensure that all residents are treated with respect and dignity and that all residents are free from abuse .Abuse: Willful infliction of injury .resulting in physical harm .Examples of abuse include but are not limited to the following: Physical - Hitting, punching, pinching, kicking . Record review of a facility reported incident of resident-to-resident abuse was submitted to the Rhode Island Department of Health on 9/17/2024. The report indicates that Resident ID #2 was being assisted out of the chair to be moved when Resident ID #1 bent over and pinched Resident ID #2 on the leg causing a skin tear. Record review revealed Resident ID #2, (the victim), was readmitted to the facility in June of 2021 with diagnoses including, but not limited to, Alzheimer's disease and type II diabetes. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 99, indicating severely impaired cognition. Review of a progress note dated 9/11/2024 at 4:09 PM revealed, Resident ID #1 told Resident ID #2 not to touch his/her food. Additionally, it revealed that Resident ID #2 was being removed from the table when Resident ID #1 reached under the table and pinched Resident ID #2 in the leg, causing a skin tear. Review of a physician's order dated 9/13/2024 revealed, clean Resident ID #2's shin skin tear with normal saline, pat dry, and apply xeroform (wound treatment) to wound bed and cover with a foam dressing, every 3 days. Review of the September 2024 Treatment Administration Record revealed, Resident ID #2's wound was treated from 9/13/2024 through 9/28/2024, a duration of 22 days. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed Resident ID #1, (the perpetrator) was admitted to the facility in August of 2022 with a diagnosis including, but not limited to, dementia. Review of a quarterly MDS assessment dated [DATE], revealed a BIMS score of 3 out of 15, indicating severely impaired cognition. Review of a progress note dated 9/11/2024 at 4:09 PM revealed, Resident ID #1 told Resident ID #2 not to touch his/her food. Additionally, it revealed that Resident ID #2 was being removed from the table when Resident ID #1 reached under the table and pinched Resident ID #2 in the leg, causing a skin tear. During a surveyor interview on 10/3/2024 at 8:24 AM with Nursing Assistant, Staff A, she revealed Resident ID #1 told Resident ID #2 not to touch his/her food. She further revealed that when staff intervened with the family to separate Resident ID #2 from Resident ID #1, Resident ID #1 reached under the table and pinched Resident ID #2. During a surveyor interview on 10/3/2024 at 9:54 AM with the Unit Manager, she revealed Resident ID #2 attempted to touch Resident ID #1's food and that the residents were being separated. She revealed that during staff and family intervening to separate the resident's, Resident ID #1 reached under the table and pinched Resident ID #2, which resulted in a skin tear on his/her leg that required a treatment. A surveyor interview was attempted on 10/3/2024 at 11:13 AM with Resident ID #2 but the resident was unable to recall the above-mentioned incident due to impaired cognition. A surveyor interview was attempted on 10/3/2024 at 11:50 AM with Resident ID #1 but the resident was unable to recall the above-mentioned incident due to impaired cognition. During surveyor interviews on 10/3/2024 at 9:31 AM and approximately 1:30 PM with the Director of Nursing Services, she acknowledged that Resident ID #1 pinched Resident ID #2's leg resulting in a skin tear. Additionally, she was unable to provide evidence that Resident ID #2 was kept free from physical abuse.

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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 - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46539 Based on record review and staff interview, it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice and the comprehensive care plan relative to 1 of 1 resident reviewed with a skin tear, Resident ID #2. Findings are as follows: Record review revealed Resident ID #2 was readmitted to the facility in June of 2021 with diagnoses including, but not limited to, Alzheimer's disease and type II diabetes. Review of a progress note dated 9/11/2024 revealed, a resident reached under a table and pinched Resident ID #2 in the leg, resulting in a skin tear. Review of a physician's order dated 9/13/2024 revealed, clean Resident ID #2's shin skin tear with normal saline, pat dry, and apply xeroform (wound treatment) to wound bed and cover with a foam dressing, every 3 days. Review of the September 2024 Treatment Administration Record revealed, Resident ID #2's wound was treated from 9/13/2024 through 9/28/2024, a duration of 22 days. Review of a skin assessment dated [DATE] revealed, the resident had a skin tear with the following instructions related to documentation which should include, the type of wound (abrasion, pressure, skin tear, etc.), measurements of wound length by width by depth, odor, edema, edges, type of tissue in the wound bed, evidence of infection, pain, drainage type and amount, and surrounding skin. Record review failed to reveal evidence at the time of the skin tear or during the following skin assessment on 9/16/2024 that the wound documentation in the medical record included the size of the wound, wound edges, and the wound bed, shape, and the condition of surrounding tissue, per the regulation. During a surveyor interview on 10/3/2024 at 12:40 PM with the Unit Manager, she revealed that the wound was a flap of skin that was pinched and that the wound did bleed at the time of the initial injury. Furthermore, she acknowledged that the residents wound was not measured and there was no identifying characteristics of the wound documented. A surveyor interview was attempted on 10/3/2024 at 11:13 AM with Resident ID #2 but the resident was unable to recall the the above-mentioned incident related to impaired cognition. During surveyor interviews on 10/3/2024 at 9:31 AM and approximately 1:30 PM with the Director of Nursing Services, she acknowledged that there was no documentation regarding Resident ID #2's skin tear on 9/11/2024 or 9/16/2024.