

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Saint Elizabeth Home East Greenwich		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43987</p> <p>Based on record review, staff and resident interview it has been determined that the facility failed to ensure that a newly admitted resident received adequate supervision to prevent an elopement for 1 of 1 resident reviewed who successfully eloped from the facility, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Record review of a facility reported incident submitted to the Rhode Island Department of Health (RIDOH) on 1/2/2025 states in part, Patient left facility without alerting staff. Patient was unable to re-enter the building and decided to walk. [NAME] by called 911 and patient was sent to ER [emergency room] for evaluation.</p> <p>Review of a community reported complaint submitted to the RIDOH on 1/2/2025 alleges that Resident ID #1 eloped from the facility and was found sitting on a main road and taken to the hospital at approximately 3:00 AM. It further revealed that the resident's family member was not notified by the facility that the resident was unable to be located during rounds until 7:14 AM. This was approximately 3 hours after the resident was found sitting in the road.</p> <p>Record review of a facility policy titled Missing Resident Policy states in part, Purpose: To provide direction to staff when a resident is determined to be missing or has eloped. Notify the Person in charge and/or charge nurse. Determine the time that the resident was discovered missing and when and where he/she was last seen .Check with other staff. Contact family to ask them if the resident is with them. If unable to determine where the resident is, notify other staff in the building and promptly search the facility and premises .If missing resident is not found following and expedite search (approximately 30 minutes), call 9-1-1 and provide Name of the resident, Date/time and location resident was last seen .</p> <p>Record review revealed that Resident ID #1 was admitted to the facility on [DATE] at approximately 2:00 PM, after a hospital stay. S/he was discharged after a fall with a head strike and a left basal ganglia intraparenchymal hemorrhage (a hemorrhage inside the brain that is primarily caused by uncontrolled hypertension.) While in the hospital the resident was alert and oriented times two and experienced periods of forgetfulness.</p> <p>Record review of a progress note dated 1/1/2025 at 4:58 PM by Registered Nurse (RN), Staff A, revealed that the resident was observed with intermittent confusion and forgetfulness.</p> <p>(continued on next page)</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
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of the January 2025 Medication Administration Record revealed that the resident received his/her evening medications at 8:08 PM on 1/1/2025.</p> <p>Further record review failed to reveal evidence of the resident's whereabouts from approximately 8:00 PM on 1/1/2025 until approximately 7:15 AM on 1/2/2025 when they were made aware by the resident's family member that s/he was at the hospital.</p> <p>Record review of a Police Department Call Log dated 1/2/2025 states in part, ELDERLY [person] IN THE LOBBY VERY CONFUSED AND COLD . Additionally it states that the resident did not know where s/he lived and was transferred from the police station by Rhode Island Emergency Medical Services (EMS) to an acute care hospital for an evaluation.</p> <p>Record review of an EMS Report dated 1/2/2025 revealed in part, .Hypothermic [significant and potentially dangerous drop in body temperature mostly caused by prolonged exposure to the cold] Primary Symptom: Altered mental status .pt [Resident ID #1] sitting in lobby of police station wrapped in a mylar blanket [an emergency blanket used to keep a person warm], shivering, in pajamas with cold wet socks on, no shoes .Pd [police department] stated that pt [Resident ID #1] was dropped off from a newspaper delivery person who found the pt [Resident ID #1] walking in Post Road . Pt is cold .has decrease mental state .obviously confused and not answering all questions appropriately . Pt states that [s/he]went out when it was light out to bring flowers to President Cartes [sic] Memeorial [sic] but got locked out and could not get back inside. Pt was unable to tell EMS if [s/he] was home or from a nursing facility .Removed cold wet socks, placed .in heated ambulance .and transfer to [hospital name redacted] .</p> <p>Review of an emergency room note dated 1/2/2025 revealed in part, .presented for evaluation of being found wandering around the road .for altered mental status. Patient was hypertensive [high blood pressure] to a systolic blood pressure greater than 180 on arrival [normal systolic blood pressure range is considered to be less than 120] .Contacted [family member] over the phone who was not aware the patient was in the Emergency Department .</p> <p>Record review revealed the resident returned from the hospital to the facility during the evening shift (3:00 PM through 11:00 PM) of 1/2/2025.</p> <p>During a surveyor interview on 1/3/2025 at approximately 12:00 PM, with the Administrator she acknowledged that the resident eloped from the facility unsupervised. She further revealed that both the 1st and 2nd floor doors had alarms that would have been activated when s/he left the facility. Additionally, she revealed that staff had not responded to any alarms on the night shift of 1/1-1/2/2025.</p> <p>During a subsequent interview with the Administrator on 1/6/2025 at 9:14 AM, she revealed that the alarms on the doors had been turned off by staff members. Additionally, she revealed that the facility would be placing additional alarms on the doors that will require a key for deactivation. Furthermore, she indicated that the keys for these alarms will remain with the nurse on the unit.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During a surveyor interview with the resident on 1/3/2025 at approximately 1:00 PM s/he revealed that s/he remembers walking out of the building but could not recall the time of day. Additionally, the resident stated in part, there was no one there it was quiet, and I just walked out. Furthermore, s/he revealed that once s/he was outside s/he was cold because s/he did not have a coat or shoes on. Lastly, s/he revealed that s/he was waving his/her arms and a person helped him/her by taking him/her to the police station, where they gave him/her a blanket and transferred him/her to the hospital.</p> <p>Record review of a written statement dated 1/2/2025, by Licensed Practical Nurse (LPN), Staff C, the charge nurse on the resident's unit on 1/1/2025 from 3:00 PM to 11:00 PM, revealed that she had last observed the resident sometime between 8:00 PM and 9:00 PM on 1/1/2025.</p> <p>During a surveyor interview with Staff C on 1/13/2025 at 2:51 PM, she revealed that she did not administer medications to the resident on the evening of 1/1/2025. She revealed that a medication technician had administered the resident's medication. She further revealed that she did not see the resident after 9:00 PM, noting that the last time she observed the resident on the unit was sometime between 8:00 and 9:00 PM.</p> <p>Record review of a written statement by LPN, Staff B, the charge nurse on the resident's unit from 11:00 PM on 1/1/2025 to 7:00 AM on 1/2/2025 revealed that during his shift he did not see or interact with Resident ID #1.</p> <p>During a surveyor interview on 1/14/2025 at 8:13 AM with Staff B, he revealed that he never conducted rounds of the unit on the third shift of 1/1 into 1/2/2025. He stated that he only responded to calls for the residents that needed medication. He acknowledged that he did not assess the newly admitted resident who had recently experienced a brain bleed. He stated that he was notified that Resident ID #1 was missing at approximately 6:00 AM on 1/2/2025. Additionally, he revealed that he looked for the resident for about 10 to 15 minutes, during which time he did not remember anyone assisting him. Staff B, then contacted the on call Manager, Registered Nurse (RN), Staff F at approximately 6:20 AM, who instructed him to read an education book and to follow the appropriate steps of the missing resident policy. Staff B was unable to find the book, so Staff F proceeded to read him the steps over the telephone. Staff B informed the unit's staff that the resident was missing, and a search was initiated. Staff B further revealed that the resident had not been seen by any of the facility's staff since approximately 8:00 PM on 1/1/2025 and that staff members were unsure if the resident went missing on the second or third shift. Lastly, Staff B revealed that before 7:00 AM, a different Nurse Manager, Staff E arrived at the facility and took over the investigation.</p> <p>During a surveyor interview on 1/6/2025 at 10:46 AM with the Nurse Manager, Staff E, she revealed that she arrived to work on 1/2/2025 at approximately 6:50 AM and was made aware that all staff were looking for the resident. Additionally, she indicated that she contacted the resident's family member at approximately 7:15 AM to inform them that the resident was missing. At that time the family member informed her that s/he had already been contacted by the EMS and the police. Staff E acknowledged that the facility did not follow the missing resident policy protocol which includes to notify the family and to notify the police within 30 minutes.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During a surveyor interview on 1/3/2025 at approximately 2:00 PM with Nursing Assistant (NA), Staff D, he revealed that when he presented to work on 1/1/2025 for the 11:00 PM to 7:00 AM shift he did not receive report from the prior shift because it was hectic. Additionally, he stated that when he went to check on the resident's room, at approximately 11:30 PM, Resident ID #1 was not there. He further revealed that the resident's bed had no linens on it, so he assumed that s/he had been sent out to the hospital. Further, he revealed that at approximately 5:00 AM the nurse requested that the resident's vital signs be obtained and he notified the nurse that Resident ID #1 was not in his/her room.</p> <p>During a surveyor interview on 1/3/2025 at approximately 2:30 PM with the Director of Nursing Services (DNS) she acknowledged that Resident ID #1 was unaccounted for by staff since approximately 8:00 PM on 1/1/2025. She acknowledged that Staff E was notified by the family member that Resident ID #1 was in the hospital. The DNS further acknowledged staff did not properly follow the missing resident policy. Additionally, she could not provide evidence that the facility ensured the resident received adequate supervision to prevent the elopement.</p> <p>The facility failed to ensure the resident environment remains as free of accident hazards as is possible for all residents that are deemed as elopement risks as the facility staff turned off the door alarms. Additionally, after the IJ had been identified the facility did not complete their original immediate plan in its entirety by installing additional alarms. These failures placed all residents deemed as an elopement risk at continued risk from 1/1/2025 through 1/8/2025. Resident ID #1 was last seen at approximately 8:00 PM on 1/1/2024. The weather was approximately 37 degrees Fahrenheit with intermittent snow showers. The resident was not wearing a coat or shoes, s/he only had slipper socks on. Staff B, the charge nurse on the 11:00 PM to 7:00 AM shift acknowledged that he failed to conduct rounds and failed to observe the resident. At approximately 5:30 AM on 1/2/2025 almost 9 hours after the Resident was last seen, Staff B was notified that the resident was missing, and he started to look for him/her. The on call nurse was contacted at approximately 6:20 AM, and she instructed him on the appropriate steps of the missing resident policy. Staff E arrived at the facility at 6:50 AM on 1/2/2025 and was made aware the resident was missing and at approximately 7:15 AM s/he contacted the resident's family. Staff E contacted Resident's ID #1's family at approximately 7:15 AM who informed her that the resident was in the hospital. The facility's failure to supervise a confused resident resulted in the resident's elopement from the facility. This placed the resident at risk for more than minimal harm, impairment, or death, as they failed to implement appropriate interventions to keep him/her safe.</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>43987</p> <p>Based on record review and staff interview, it has been determined that the facility was not being administered in a manner that enabled it to utilize resources effectively and efficiently to maintain the highest practicable physical, mental, and psychosocial well-being of each resident related the elopement of Resident ID #1. This failure resulted in an Immediate Jeopardy for F 689.</p> <p>Findings are as follows:</p> <p>Record review of a facility policy titled Missing Resident Policy states in part, Purpose: To provide direction to staff when a resident is determined to be missing or has eloped. Notify the Person in charge and/or charge nurse. Determine the time that the resident was discovered missing and when and where he/she was last seen .Check with other staff. Contact family to ask them if the resident is with them. If unable to determine where the resident is, notify other staff in the building and promptly search the facility and premises .If missing resident is not found following and expedite search (approximately 30 minutes), call 9-1-1 and provide Name of the resident, Date/time and location resident was last seen .</p> <p>Record review revealed that on 1/2/2025 at approximately 4:00 AM, Resident ID #1 was observed by a passerby sitting down in a busy main roadway, unsupervised by staff. The resident was taken to the police station where emergency medical services were called to transport the resident to the hospital. Additionally, the temperature at the time was approximately 37 degrees Fahrenheit with intermittent snow showers.</p> <p>Review of video footage dated 1/2/2025 at 2:31 AM revealed Resident ID #1 was wandering around the main entrance of an Assisted Living Residence located 0.2 miles from the facility, without a coat or shoes on.</p> <p>During a surveyor interview on 1/14/2025 at 8:13 AM with Staff B, he stated that he was notified that Resident ID #1 was noted to be missing at approximately 6:00 AM on 1/2/2025. Additionally, he revealed that he looked for the resident for 10 to 15 minutes. He does not remember anyone assisting him in his search for the missing resident. At this time Staff B contacted the on call Manager, Registered Nurse (RN), Staff F at approximately 6:20 AM, who instructed him to read an education book in order to follow the appropriate steps for the missing resident policy, which was located in an office. Staff B revealed he was unable to locate the book, so Staff F proceeded to read him the steps on what to do over the telephone.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During surveyor interviews on 1/13/2025 at 1:15 PM and 1:42 PM with the Director of Nursing Services (DNS), she revealed that Resident ID #1 was last seen at approximately 8:00 PM on 1/1/2024. Additionally, she revealed that on call manager, Staff F was notified at 6:20 AM on 1/2/2025 that the resident was missing and that she was notified approximately two minutes later. Additionally, she revealed that she arrived at the facility was at approximately 7:25 AM. Furthermore, she revealed that Staff E contacted Resident's ID #1's family at approximately 7:15 AM who informed her that the resident was in the hospital. She furthermore acknowledged that the resident was unaccounted for by the facility for an extended period of time, approximately 10 hours after she was last seen by the second shift staff. Lastly she acknowledged that the staff did not properly follow the elopement policy and failed to notified family and the police timely.</p> <p>During a surveyor interview on 1/3/2025 at approximately 12:00 PM, with the Administrator she acknowledged that the resident eloped from the facility unsupervised even though there were two alarmed doors located on the 1st and 2nd floors that s/he would have to have activated when s/he left the facility. Additionally, she revealed that staff had not responded to any alarms on the night shift of 1/1-1/2/2025.</p> <p>During a subsequent interview with the Administrator on 1/6/2025 at 9:14 AM, she revealed that the alarms on the doors had been turned off by staff. Furthermore, she revealed that facility would be placing additional alarms on the doors and the keys to deactivate them will remain with the nurses on the unit, so that staff will unable to turn them off.</p> <p>During an additional surveyor interview on 1/13/2025 at 4:56 PM with the Administrator, she acknowledged that Resident ID #1 was unaccounted for an extended period and left the facility unsupervised and was seen on another facilities video footage at 2:31 AM. In addition, she acknowledges that facility staff did not follow the facility's policy for a missing resident. She furthermore stated that during this incident, everything that could go wrong, went wrong.</p> <p>Cross reference F689</p>		