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	06/04/2025

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** Based on record review and staff interview, it has been determined that the facility failed to keep a resident free from physical abuse for 1 of 3 residents reviewed, Resident ID #1. Findings are as follows: Review of a facility reported incident submitted to the Rhode Island Department of Health on 5/13/2025, revealed in part, that Resident ID #s 1 and 2 were sitting in the dining room, at opposite ends of a table, when Resident ID #2 walked over to Resident ID #1 and struck him/her in the face multiple times. Further review revealed both residents were immediately separated, Resident ID #1 was assessed for injury, with no injury noted, and Resident ID #2 was sent to the hospital for a geriatric psychiatric evaluation. Review of a policy titled, Abuse Prohibition last revised 1/17/2023 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 . DEFINITIONS .Abuse: willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish and includes physical .Examples of abuse include but are not limited to .Physical-Hitting, punching . Record review revealed that Resident ID #1, the victim, was admitted to the facility in December of 2023 with a diagnosis including, but not limited to, dementia. Review of Resident ID #1's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating the resident has severely impaired cognition. Record review revealed that Resident ID #2, the perpetrator, was admitted to the facility in August of 2023 with a diagnosis including, but not limited to, dementia. Review of Resident ID #2's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 4 out of 15, indicating the resident has severely impaired cognition. (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

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	06/04/2025

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	Review of Resident ID #2's care plan revealed a focus area, last revised on 7/26/2024, which indicated the resident has a history of physical aggression related to his/her diagnosis of dementia and poor impulse control. An intervention includes, but is not limited to, I appear to be triggered by increased stimulation from my peers and become agitated, staff will encourage me to go to a quieter area. Record review for Resident ID #2 revealed a progress note dated 5/13/2025 at 5:11 PM, which states in part, Elder was sitting in the dining room with [his/her] peers, elder had no [signs or symptoms] of agitation or aggression when this writer saw elder approximately 5 [minutes] prior to incident. Staff report that [Resident ID #2] got up from [his/her] chair and walked over to another elder and struck other elder in the face multiple times causing other elder's glasses to fall off. Incident appeared to be unprovoked by other elder. At the time of the incident there was increased stimulation in the dining room and activity room and other elder was repeating phrases to [him/herself] which is normal .NP [Nurse Practitioner] aware of incident and elder to be sent out to geri-psych . Record review for Resident ID #1 revealed a progress note dated 5/13/2025 at 5:00 PM, which states in part, Elder was involved in an altercation with another elder this evening. [Resident ID #1] was sitting in a chair in the dining room across from other elder, [s/he] was calm but repeating mamma what do I do? Mamma where do I go. [His/her] repetition of phrases is per usual for elder, [s/he] was calm and the volume of [his/her] talking .was low. Other elder got out of [his/her] chair and walked over to [Resident ID #1], [s/he] struck [him/her] multiple times in the face and [Resident ID #1's] glasses fell off. Staff immediately intervened and elder's were separated. [Resident ID #1] was assessed for injury with no redness, bruising or swelling noted. Elder denies pain and has no non-verbal [signs or symptoms] of pain. [Resident ID #1] was assisted out of the dining room and into the activity room. [Resident ID #1] was in a pleasant mood once [s/he] arrived to the activity room and had no recollection of the incident when talking to this writer . Review of an assessment titled Skin Incident Report, for Resident ID #1, dated 5/14/2025, revealed the resident had a change in skin integrity due to the incident with Resident ID #2 on 5/13/2025. Further review revealed the following skin impairments: - right dorsal (the top) hand bruise measuring 0.3 centimeters (cm) X 0.3 cm - 2 bruises to his/her left forearm measuring 0.4 cm X 0.2 cm and 0.3 cm X 0.3 cm - 2 linear scratches to his/her right lower forearm measuring 1.5 cm X less than (<) 0.1 cm and 1.3 cm X < 0.1 cm (continued on next page)

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	06/04/2025

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	Review of a witness statement, authored by Hospice Registered Nurse, Staff A, dated 5/13/2025, states in part, In the late afternoon of 5/13/25 I was taking a patient back into the dinning room. Upon my approach I heard two residents arguing and yelling loudly. When I entered the dinning room I saw [Resident ID #1] on a chair at one end of the table, [s/he] was facing me and turned slightly into the table. [Resident ID #2] was positioned at [Resident ID #1's] left back and side, [Resident ID #2] had one arm positioned down from [Resident ID #1's] shoulder and chest and with [his/her] other hand [s/he] was punching [Resident ID #1]. [Resident ID #2] knocked [Resident ID #1's] glasses askew. I said loudly 'no, no, no' and walked toward the scuffle. [Resident ID #2] stopped hitting [Resident ID #1] and went back to where [s/he] was sitting at the other end of the table. [Resident ID #1] continued to yell at [Resident ID #2] about [him/her] shutting up .Staff then came and removed [Resident ID #2] from the table. During a surveyor interview on 6/4/2025 at 2:43 PM, with Unit Manager, Staff B, she revealed that initially, no staff were present in the dining room when the incident occurred, as one had just left to assist with care. She revealed that Staff A entered the dining room and saw Resident ID #2 hitting Resident ID #1 in the face. She further revealed that the following day, a full skin assessment was completed on Resident ID #1, due to this incident, and the resident was noted to have bruises and scratches on his/her arms, indicating they were consistent with defensive marks. Further, she revealed that Resident ID #2 has been involved in previous resident to resident incidents and was being followed by psychiatric services. During a surveyor observation on 6/4/2025 at 3:10 PM, Resident ID #1 was observed sitting outside with his/her peers. When approached by the surveyor and Staff B, s/he appeared pleasantly confused and in good spirits. Additionally, s/he was unable to be interviewed due to his/her cognitive impairment. During a surveyor interview on 6/4/2025 at 3:23 PM, with the Director of Nursing Services, she revealed that Resident ID #2 has been involved in previous resident to resident incidents, with the last one occurring in August of 2024. She further revealed that Resident ID #2 has a history of behaviors and indicated that s/he was completely unprovoked during the resident-to-resident incidents. She further revealed that Resident ID #2 was admitted to the hospital for a geriatric psychiatric evaluation, following this incident, and the decision was made to not accept him/her back to the facility due to safety concerns. Additionally, she was unable to provide evidence that Resident ID #1 was kept free from abuse.